



**Manchester
Metropolitan
University**

Chesterton, Lorna Elizabeth (2018) Professional accountability and the nurse: a Heideggerian hermeneutical study. Doctoral thesis (PhD), Manchester Metropolitan University.

Downloaded from: <https://e-space.mmu.ac.uk/622564/>

Usage rights: Creative Commons: Attribution-Noncommercial-No Derivative Works 4.0

Please cite the published version

<https://e-space.mmu.ac.uk>

Professional Accountability and the Nurse: A Heideggerian Hermeneutical Study

Lorna Elizabeth Chesterton

A thesis submitted in partial fulfilment of
the requirements of the Manchester
Metropolitan University for the degree of
Doctor of Philosophy

Department of Nursing

July 2018

Acknowledgements

My most grateful thanks to my supervisory team: Director of Studies, Professor Josie Tetley, alongside Dr Kirsten Jack and Dr Nigel Cox, without whose exemplary support, mentorship and kindness none of this would have been possible. Their combined wisdom, positivity and accessibility have made this journey a valuable and enjoyable learning experience.

To the participants who generously gave me their time, openness and honesty.

To my wonderful husband, Nick, and my precious children, James, Charlotte, Matthew and Oliver, for always believing in me.

To my parents, for inspiring and supporting me throughout my life.

I regret that my Dad did not live to see me complete this PhD, so it is to him that I dedicate this thesis.

Abstract

Professional accountability in nursing is considered the foundation of nursing practice and governs the individual's professional standards and responsibilities (NMC, 2015a). The ideals contained within professional accountability are linked to clinical governance through the provision of high quality safe care delivery (Urgent and Emergency Care Review Team, 2013). Historical and contemporary government investigations have consistently highlighted a negative organisational culture in the NHS, and specifically in nursing, questioning the extent to which the ideals of professional accountability in reality impact upon patient care. In order to bridge the gap between theory and practice, this study explores how nurses experience and perceive professional accountability in their everyday working practices. The philosophy of Martin Heidegger (1927/2010) guides this Heideggerian hermeneutical approach, allowing new meanings to be uncovered. Data were collected from seven in-depth interviews with qualified nurses, working in the NHS and their analysis guided by Heidegger's (1927/2010) concept of the hermeneutic circle, a process that values the interpreter's experience and values. Essential concepts and meanings are arranged into headings, patterns and structures, a technique underpinned by the work of van Manen (1984). This interpretive approach illustrates how historical, cultural, political and social constructs have influenced and affected nurses' understanding, actions and meanings in relation to professional accountability in practice. The essential concepts, conceptualised through a hermeneutic lens, are culture, fear, self-protection, positive and negative collegial relationships, effects upon nursing care, management and professional accountability. A discussion of the findings then fuses together the essential concepts with contemporary literature and my own changing perceptions to conceptualise new ideas. The study findings are used to make recommendations for nursing through policy, practice, education and research. The recommendations focus on building upon areas of existing good practice to develop a positive culture in nursing, facilitated by changes in management, governance and support.

Table of Contents

| | |
|----------------------------------------------------------------------------------------------------------|----|
| Acknowledgements | 2 |
| Abstract | 3 |
| Table of Contents | 4 |
| Forward | 8 |
| Co-constituting the data | 8 |
| Structure of this thesis | 9 |
| Conventions used in this thesis | 10 |
| Less conventional aspects of this thesis | 10 |
| Chapter One: Professional Accountability | 13 |
| Overview | 13 |
| Accountability | 13 |
| Professional accountability in nursing | 15 |
| The culture of nursing | 16 |
| Nurses' professional accountability | 18 |
| Table 1: Algorithm by Leonard and Frankel (2010) | 21 |
| Nurses' professional accountability to the organisation | 22 |
| Nurses' professional accountability to their regulatory body, the NMC | 23 |
| Background | 23 |
| The code: professional standards of practice and behaviour for nurses and midwives (NMC, 2015a) | 26 |
| Accountability of the NMC | 27 |
| Summary | 28 |
| Aims of this study | 29 |
| Chapter Two: The National Health Service (NHS) in the UK | 31 |
| Overview | 31 |
| Background | 31 |
| Failures in healthcare | 34 |
| Table 2: Government investigations into NHS hospital trusts | 35 |
| Chapter Three: The Research Approach | 42 |
| Overview | 42 |
| Introduction | 42 |
| Phenomenology | 43 |
| Edmund Husserl (1859–1938) | 45 |
| Descriptive (eidetic) phenomenology | 46 |
| Heideggerian phenomenology (hermeneutics) | 50 |

| | |
|------------------------------------------------------------------------------------|-----|
| Martin Heidegger (1889–1976) | 51 |
| Heideggerian concepts | 52 |
| Phenomenology and nursing | 56 |
| Phenomenological based studies in nursing | 57 |
| Chapter Four: Methodology | 63 |
| Overview | 63 |
| Introduction | 63 |
| Selecting a methodology | 64 |
| Personal reflections and methodological approach | 69 |
| Reflecting upon <i>fore-structures</i> and preunderstandings | 71 |
| Revisiting the aims and objectives of this study | 74 |
| Interpretation and understanding | 79 |
| The experience of <i>being</i> in professional accountability | 80 |
| Maintaining quality through rigour | 81 |
| Chapter Five: The Research Process | 83 |
| Overview | 83 |
| Introduction | 83 |
| Ethical approval | 83 |
| Consent and right to withdraw | 84 |
| Data protection | 85 |
| Risks, burdens and benefits | 85 |
| Access to the field | 86 |
| ‘Sampling’ or ‘selecting participants’ | 87 |
| Data collection | 88 |
| Table 3: Advantages and disadvantages of using semi-structured interviews | 89 |
| Interview format/ procedure | 91 |
| Member checking | 93 |
| The participants involved in this study | 94 |
| Table 4: Participants involved in the study | 97 |
| My approach to data analysis | 98 |
| Chapter Six: Data Analysis: The Essential Concepts | 100 |
| Overview | 100 |
| Introduction | 100 |
| The essential concepts | 101 |
| Table 5: Essential concepts: links to practice and Heideggerian concepts | 101 |
| Essential Concept 1: The culture of the NHS in its <i>being-in-the-world</i> | 103 |
| Introduction | 103 |

| | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| Essential Concept 1 | 104 |
| Essential Concept 2: The existential constitution of <i>the-there</i> | 118 |
| <i>A mode of attunement: fear: the concept of fear in being-in-the-world</i> in relation to the culture of the NHS | 118 |
| Introduction | 118 |
| Essential Concept 2 | 118 |
| Essential Concept 3: Self-preservation within the culture of the NHS | 134 |
| Introduction | 134 |
| Essential Concept 3 | 135 |
| Essential Concept 4: <i>Being-with (Mitsein)</i> : positive collegial relationships in <i>being-in-the-world</i> relating to the nurses' <i>lifeworld</i> | 140 |
| Introduction | 140 |
| Essential Concept 4 | 140 |
| Essential Concept 5: <i>Being-with (Mitsein)</i> : negative collegial relationships | 153 |
| Introduction | 153 |
| Essential Concept 5 | 153 |
| Essential Concept 6: Care and <i>solicitude</i> in <i>being</i> a nurse relating to the complex challenges in care provision | 162 |
| Introduction | 162 |
| Essential Concept 6 | 164 |
| Essential Concept 7: Management with regard to <i>solicitude</i> in <i>being-in-the-world</i> | 174 |
| Introduction | 174 |
| Essential Concept 7 | 174 |
| Essential Concept 8: Professional accountability in nursing | 183 |
| Introduction | 183 |
| Essential Concept 8 | 184 |
| Chapter Seven: Discussion | 197 |
| Overview..... | 197 |
| A review of the aims of this study | 197 |
| Introduction | 197 |
| Contextual Headings used in this Discussion | 199 |
| Culture | 200 |
| Management and Leadership | 208 |
| Professional accountability | 215 |
| The emotional costs of nursing | 220 |
| Resilience in nursing..... | 226 |
| Chapter Eight: Recommendations | 233 |

| | |
|---------------------------------|-----|
| Overview..... | 233 |
| Introduction..... | 233 |
| Recommendations..... | 235 |
| Policy..... | 237 |
| Practice..... | 239 |
| Education..... | 240 |
| Research | 241 |
| Limitations of this study | 242 |
| Dissemination | 243 |
| Personal learning..... | 244 |
| Concluding remarks..... | 245 |
| References..... | 247 |
| Appendices | 316 |
| Appendix 1..... | 316 |
| Appendix 2..... | 317 |
| Appendix 3..... | 318 |
| Appendix 4..... | 320 |
| Appendix 5..... | 321 |
| Appendix 6..... | 323 |

Forward

This doctoral thesis presents evidence of how nurses cope with the complex challenges to their individual professional accountability. The findings from this study provide valuable insights into the nurse's *lifeworld* which drive recommendations for policy, practice and education. I will demonstrate how these findings intersect and are supported by current literature and add new knowledge to the existing body of evidence. The main implications that emerged from this research highlight the need for a positive practice environment, facilitated by effective management and leadership. Adequate staffing and changes in governance are considered prerequisites in order to establish a safe system of healthcare. The key messages from this research have the potential to instigate much needed change and facilitate retention of nurses at a time when nurse shortages are threatening to undermine healthcare, both nationally and internationally (WHO, 2018).

Co-constituting the data

As a registered nurse, this study is connected to my own biography, and throughout the thesis, I co-constitute my own experiences with those of the participants and the philosophy of Heidegger. As a nurse with over thirty years of experience in clinical practice many of the issues discussed have had a personal significance to me. Indeed, Denzin and Lincoln (2003) assert the importance of the researcher conveying their personal and historical situatedness to the research and any preconceptions which may influence the study. Certainly, looking back to when I commenced the study I had a somewhat cynical attitude to nursing, borne from my most recent experiences of working in a community setting. The autonomous nature of the role and the limited resources available meant that stress was a constant companion. Whilst it was not possible to set aside my own *priori* knowledge or experience it was possible to recognise these preconceptions in articulating my *forestructures* which I reflect upon in Chapter four. Heidegger (1927/2010) acknowledges that researcher *bias* helps us to understand and make sense of experiences and in this way can enrich the data, by enhancing or influencing the process of analysis.

This thesis will reveal how my own experience is added to the voices of the participants, and the philosophy of Heidegger (1927/2010). I utilise my own *priori* experiences of being a nurse to co-constitute the data, achieving a fusion of horizons (Gadamer, 1975/1996). This can be observed when participants spoke about self-preservation, in the context of raising concerns. My horizons shifted from initially seeing their actions as being attributable to fear, and then following a period of reflection, recognising that they had actually weighed up the possible risks and chosen to adopt an *inauthentic* mode of *being*. It is hoped that by sharing my own experiences and shifts in thinking, I demonstrate transparency and credibility throughout this study. In carrying out this study I was able to recalibrate my emotional being and my attitude towards nursing. I am now able to see my journey in nursing as a tapestry of memories, made up of the rich experiences which I have been involved in.

Structure of this thesis

This thesis is comprised of eight chapters. Chapter One defines and discusses the concepts of accountability and professional accountability and how this relates to nurses' responsibilities regarding patient care. The historical perspectives of nursing culture are discussed in this opening chapter and this thread continues into Chapter Two where a chronological view of the NHS in the UK is presented. Chapter Two also makes reference to numerous government investigations in healthcare over the last 15 years, and looks at common themes which are apparent. By describing the links between governance and safety, this chapter nests the study in the context of the wider picture and the challenges nurses face in relation to their professional accountability. Chapter Three goes on to describe the philosophical work underpinning this study and attempts to explain the significance and relevance of this theoretical work. In keeping with this philosophical stance, a discussion of the methodology selected in this study, becomes the focus for Chapter Four and describes the reflexive approach which is adopted throughout. A discussion of the Heideggerian notion of *fore-structures* and the importance of personal openness prior to commencing the study will also be addressed in this Chapter. The Fifth Chapter then outlines the practical and ethical issues addressed in the research process and will allow the reader to see a clear audit trail of the research process. Chapter Six describes the data analysis process and depicts the eight essential concepts that emerged from the

research process. In this Chapter, data gathered from in-depth interviews is presented alongside my own thoughts and the philosophical work of Heidegger (1927/2010), allowing the data to be co-constituted. Chapter Seven, will fuse together the essential concepts with available literature, allowing the findings to be contextually grounded under new headings. Chapter Eight concludes this thesis and makes recommendations for policy, practice, education and research, which are driven by the research findings of this study. This final chapter also discusses the limitations of the study and identifies the potential for dissemination.

Conventions used in this thesis

Direct quotes from the study participants are identified by using an italicised format, with quotes being indented. All direct quotes from participants are written verbatim and include colloquial language as used during the interview. Direct quotations derived from the literature are punctuated with quotation marks and accompanied by the author/s, year of publication and page number. Heideggerian terminology is italicised throughout the thesis.

Less conventional aspects of this thesis

A traditional literature review chapter generally appears at the beginning of a doctoral thesis and serves to highlight relevant research and identify key findings (Silverman, 2013). In doing so the researcher identifies gaps within the body of evidence and justifies the need for further research prior to the commencement of the study (Aveyard, 2014). Indeed, this approach provides the researcher and the reader with an understanding of the topic area and an appreciation for the central concerns (Hart, 2018). However, I have chosen to take a less conventional path and not provide a literature review chapter, an approach which has allowed me not only to connect with relevant literature throughout the thesis but also to contextualise the study in its own *historicality* at the beginning. In omitting a literature review at the onset of the study could mean that I would replicate an existing study, a tension which was acknowledged and resolved by completing a brief review of extant literature (Charmaz, 2006) In this way I was assured that I would not duplicate a similar study nor compromise the philosophy which underpins the research, allowing me to remain open

to open to new ideas, and engage with the literature as it became relevant to the study (Dick, 2007).

Philosophically, my reasoning for not completing a comprehensive literature search prior to carrying out the interviews was to prevent the literature informing my own preunderstandings (*fore-structures*), which I brought to the study. The importance of these *fore-structures* will be made explicit in Chapter Four. I had an acceptance that the preunderstandings apparent in my consciousness were informed and influenced by the culture, history, social and political beliefs of my *lifeworld*. Gadamer (1975/1996) asserts that it is important that the researcher recognises their own unique horizons, so that they are open to the possibilities of the interpretive process. Corbin and Strauss (2008) concur with this, suggesting that studying others' work may impact upon the research process and colour the researcher's perceptions. Certainly, my own views may have been changed or been influenced by studying the literature prior to commencing the study, and I could potentially have found what I already knew, or what someone else had previously found. Glaser (1992) advises that researchers enter the study with an open mind, although Birks and Mills (2015) speculate on the reality of this, concluding that it is more important to articulate one's thoughts and feelings at the onset of the study. Indeed, Koch (1995) observes that a literature review should be an ongoing process, running throughout the study. Boell and Cecez-Kecmanovic (2010) put forward the view that by following a hermeneutic process in reviewing the literature, there is a continual reinterpretation, with ever increasing understanding of the research area and the phenomenon being explored. Using the ethos of the hermeneutic circle, understanding is influenced by studying the literature, and new interpretations formed, with understanding of the parts feeding into understanding the whole and vice versa (Boell and Cecez-Kecmanovic, 2010). The process described by Boell and Cecez-Kecmanovic (2010) was certainly evident during the process of analysing the data as the text presented new ideas, which changed my perceptions, and were further influenced by the literature.

This thesis, demonstrates an engagement with the literature throughout, giving context to the study and an analysis of the data in relation to existing research (Hart, 2018). By embedding and weaving the literature into the thesis, it is able to add depth to my findings and importantly allow me to tell a story. Silverman (2013) concurs with this

approach and encourages following a more creative approach to literature reviewing. Wolcott (1990) perhaps best sums up the danger of following a more orthodox approach and isolating the literature in one early chapter:

I expect my students to know the relevant literature, but I do not want them to lump (dump?) it all into a chapter that remains unconnected to the rest of the study. I want them to draw upon the literature selectively and appropriately as needed in the telling of their story. (Wolcott, 1990: 17)

It was therefore my aim to use the literature to support the work throughout, and embed it within the thesis (Wolcott, 1990). Indeed, Charmaz (2006) asserts that while researchers strive for objectivity in conducting a literature search prior to the study commencing, the review is, by its nature, both ideological and pragmatic. Moreover, Glaser (1998) warns against an extensive literature search at the outset, before findings are known, as this may prove inefficient and later of little relevance. A point concurred by Dick (2007). Furthermore, it was important that the study was viewed through a hermeneutic lens, to find new meanings from a different viewpoint. An example of this would be when participants expressed fear in facing new situations: when viewed through a hermeneutic lens, it could be seen as *Unzuhanden* coping, when the environment (*Umwelt*) was unfamiliar. This has therefore led to a more creative approach to data analysis.

Chapter One: Professional Accountability

Overview

Chapter One offers a discussion of professional accountability, a concept that lies at the very heart of nursing and clinical practice. Professional accountability provides the foundation to this doctoral thesis, since it embodies the ideals of clinical practice. However, professional accountability has the potential to be compromised by the external factors of staffing, time and resource availability. In this chapter I explore how professional accountability is defined and regulated by the individual, the employing organisation and the Nursing and Midwifery Council (NMC). Initially I look at the issue of accountability in its broadest terms, before defining what professional accountability is in relation to its importance and centrality to nursing and nursing culture. I then examine individual accountability and how external factors can have an impact upon it. Following this, I look at nurses' professional accountability to the employing organisation, with a section pertaining to the background and history of professionalism relating to the NMC (2015a) code of professional conduct to allow the reader to grasp the history and development of this fundamental concept to professional accountability in nursing. The chapter concludes with a description of the NMC code of professional standards of practice and behaviour for nurses and midwives (NMC, 2015a).

Accountability

In a broad sense, accountability is concerned with being answerable, and involves the obligation to justify and explain actions (Boven, 2005). Accountability occurs in the context of a system of values, relationships, actions and expectations (Pollit, 2003). Accountability is conceptualised by Wagner (1989:3) as a 'pervasive feature in many relationships which occur in human affairs'. Boven (2005) sees accountability being synonymous with effective governance, responsibility and integrity. From a sociological perspective, Dubnick (2003:39) views the mechanisms and responses of accountability to be answerability, blameworthiness, liability and attributability. This notion is reflective of Merton's (1968) social theory and social structure work, which posits that social processes have specific consequences within the social structure.

Merton (1968) asserts that tensions are created by society between the cultural values and the societal norms which are apparent. Mulgan (2000:1) adds to this definition by noting that there exist two notions of accountability, 'giving an account' and 'calling to account'. Individuals are governed by the external constraints of being held accountable by a senior authority, which may scrutinise and impose punitive measures, whilst those who are deemed accountable duly respond and accept any sanction applied to them. Indeed, accountability can be viewed in terms of one's legal, contractual or moral responsibilities. It is also posited by Harmon and Mayer (1986) that individuals exhibit a personal accountability, controlled by an individual's 'conscience', and reflects their values and cultural beliefs, displaying a respect for humanity and the lives of others. Personal accountability is motivated by moral and ethical principles, enforced by psychological and emotional controls (Harmon and Mayer, 1986).

The idea of accountability is therefore a complex phenomenon, which serves to govern our individual actions and decisions, in respect of social norms. In order to conform to these societal rules, one must be able to account for one's behaviour and choices, and accept the consequences for one's actions. Furthermore, there is the notion of moral and ethical accountability, driven by the individual's own values. Certainly, it is difficult to argue against the concept of accountability as a positive attribute, as it has been established as the pivotal structure of a safe organisation for any service provider. However, the concept of accountability is often viewed as sanction based; this can, according to Mansbridge (2014), undermine accountability which is based upon trust. This therefore brings up the issue of organisational management and leadership. Accountability within the context of leadership is conceived by Williams (2006) to be the recognition of responsibility in decision making, policy and governance, and incorporates the notion of being answerable for actions and subsequent consequences. However, Pollitt (1990:151) asserts that leaders within public services should find ways of 'giving account', as opposed to 'holding to account'. The issues of accountability and its links to sanctions and blame is re-examined later in the thesis in Chapter Seven, as this has important links to the NHS, and specifically to the culture of nursing. First, however, it is necessary to explore the concept of professional accountability, in relation to nursing.

Professional accountability in nursing

Professional accountability espouses the ideals of delivering high quality, patient centred, holistic care to patients in a supportive environment. However, at times these ideals and standards can be compromised by external factors that are historically, socially or politically driven. It is therefore pertinent to explore the concept of professional accountability and examine how this impacts upon being a registered nurse, and the context that surrounds it using relevant literature. Professional accountability is described as a complex phenomenon with several distinct elements (RCN, 2017b). There are three distinct features relating to professional accountability, all of which directly relate to the overarching accountability that a nurse has to his/her patients. First, the nurse has personal accountability for their own actions, omissions and quality of care. Second, it is observed that there exists professional accountability to the employing organisation. Third, there lies accountability to the regulating professional body of the Nursing and Midwifery Council. Bassett and Westmore (2012) assert that senior organisational management must also be accountable for organisational performance and provision of service.

Professional accountability in nursing is a concept which seems difficult to clarify or define according to a literature review by Krautscheid (2014). The review by Krautscheid (2014) examined literature over a 21-year period and highlighted the lack of clarity regarding definition, with consequential difficulties for nurse educators in teaching about professional accountability. Krautscheid (2014) asserts that the creation of a credible and agreed definition would provide a clear teaching platform from which to address the behaviour, knowledge, skills and attitudes pertaining to professional accountability. Crigger and Godfrey (2011) echo this notion, adding that it is of paramount importance that a pre-registration curriculum includes full reference and discussion of professional accountability if it is to support high quality patient care. Furthermore, Dyess and Sherman (2009) observe that many newly qualified nurses fail to demonstrate an understanding of accountability in either theory or professional behaviour. An ethnographic study by The Royal College of Nursing (RCN) (2004) found that clinicians felt the term accountability is difficult to articulate and quantify. Accountability is also described as a 'retrospective explanation of actions' and as a means for attributing or accepting blame. In contrast, professional accountability is

also found to be a concept that motivates behaviour and inspires good practice (RCN, 2004). Professional accountability is intrinsically influenced by the prevailing culture of nursing, since a positive open culture will encourage honesty in raising concerns and addressing incidents. Conversely, a closed blaming culture will lead to anxiety and fear of repercussions. The culture of nursing therefore becomes the focus of the next section, looking at its history and development.

The culture of nursing

The concept of culture is aligned to the collective values of a group, and culture is expressed through the values and learnt behaviours of its members (Suominen et al, 1997). Nursing is a profession steeped in ritualistic practice and tradition, serving to promote order and consistency, whilst cementing expectations for both staff and patients (Holland, 1993). Many routines, such as report giving, are daily repetitive exercises, which are performed throughout nursing disciplines and specialities. Ritualistic practices, values and social norms are taught and passed on to junior staff by experienced staff, allowing the process of professional socialisation to continue (Du-Toit, 1995). Indeed, Tradewell (1996) observes that the concept of professional socialisation was identified in the literature as far back as the 1950s. It could therefore be assumed that the perpetuation of professional socialisation is both an intentional and unintentional process within nursing and nurse education (Shinyashiki et al, 2006). The positive effects of professional socialisation consist of the attainment of a professional identity, and skills to cope with the often demanding nature of the professional role (Zarshenas et al, 2014). The negative consequences are generally regarded as low motivation, demoralisation and de-sensitivity regarding patient care (Shinyashiki et al, 2006). However, the concept of professional socialisation is complex and diverse, affecting individuals in different ways and at varying times; a process that is fluid, interactive and developmental in nature (Weidman et al, 2001). Professional socialisation is, in my opinion, an inevitable process, needed to develop knowledge and skills; its consequences and legacy could have the potential for positivity if values and role modelling demonstrate care and compassion for patients and colleagues.

The role and image of nursing has changed dramatically over the years, but it can still be viewed as an oppressed group (Ten-Hoeve et al, 2013). The notion that nurses display oppressed group attributes is posited by Roberts (1983) utilising Freire's (1970) model of oppression. Freire (1970) conceived that five dominant traits are manifested by oppressed groups: assimilation; marginalisation; self-hatred and low self-esteem; submissive-aggressive syndrome; and horizontal violence. Certainly, this could explain the negative collegial relationships frequently witnessed and documented in the literature; behaviour that is frequently construed by nurses as 'a rite of passage' according to Thomas (2010). The familiar expression 'nurses eat their young' was coined in the mid-1960s and remains a well-known but unsolved problem in the nursing profession (Hippeli, 2009). Freire's (1970) seminal work on oppression concludes that the solution to ending oppression can only be accomplished from within the group itself, by introspection, education and enlightenment.

As the nursing profession embraced education and increased the minimum academic entry to degree level (NMC, 2010), a new controversy emerged with the phrase, 'Are new nurses "too posh to wash, too clever to care?"' (Beer, 2013). These negatively inspired statements formulated the assumption that nurses achieving academic success were less interested in providing basic nursing care to patients. Critics posited that the drive for academic success was motivated by professional self-interest and was contrary to the portrayal of nursing as an altruistic vocation (Watson, 2011). Opposition to an all-graduate profession did not just come from the public; it also came from within the nursing profession, which is suggestive that nurses are limiting their own profession and opportunities for progression (Stacey et al, 2016).

Other reasons suggesting that registered nurses are not carrying out essential nursing care relates to their changing role, and the establishment of skill mixes that utilise unregistered healthcare professionals and second level nurses (nurses who are qualified at a level lower than a registered nurse). The calculations used to derive an appropriate skill mix depend upon the clinical area, acuity of patients and financial constraints, with no robust empirical formula available on which to base the decisions (Yang et al, 2012). Where historically patient care was restricted to registered nurses, such care is now often met by other healthcare professionals, which of course has implications for patient health outcomes (Ayre et al, 2007). Furthermore, a European

study by Aiken et al (2016) reports that replacing registered nurses with lower skilled nursing assistants increases the risk of patient mortality. The RCN (2016) uses evidence from Aiken et al's (2016) study to argue against the UK government's decision to introduce associate level nurses, believing patient care could be impacted by replacing registered nurses with associate nurses in an attempt to reduce costs.

Nursing skill mix has its roots in financial constraints and workforce shortages but has implications for registered nurses in terms of their accountability in delegating nursing care (RCN, 2017b). Under the directive of the Department of Health and supported by Health Education England (HEE, 2016a) the new associate nurse role was piloted in the UK. The associate nurses work independently, under the supervision of registered nurses, delivering care set out in patient care plans. Furthermore, a permanent shortage of nurses threatens to worsen, as the profession of nursing continues to appear on the Home Office national shortage occupation list (RCN, 2017a). There is an urgent need to recruit and retain nurses, with 40,000 vacant nurse posts in England (RCN, 2017a). The nurse shortages will be further impacted as one in four nurses approaches retirement and abolition of bursary grants reduces recruitment, alongside the threat of fewer EU nurses migrating to Britain following Brexit (RCN, 2017a).

Nurses' professional accountability

Nurses are legally accountable to their patients under civil law, under the torts of negligence, trespass and other civil wrongdoings (Cox, 2010). Furthermore, nurses are also legally accountable to the public under criminal law. Two landmark court cases redefined professional negligence law and changed the way that health professionals are judged in law. The cases in question were *Bolam v Friern Hospital Management Committee* (1957) and *Bolitho v City and Hackney Health Authority* (1997). The earlier case of *Bolam*, historically referred to as the 'Bolam test', saw health professionals judged by a responsible body of professional opinion and acted with the standards of a reasonable professional. Briefly, the case involved a patient being given electro-convulsive therapy without the administration of muscle relaxants or restraints. Consequentially, he was left with serious injuries. The patient alleged he was not given adequate warnings of the risks involved. The court ruled in favour of the defendant hospital, citing that the medics involved had followed common practice,

according to expert witnesses. The ruling appeared to protect medics to some degree, as it was difficult for a claimant to overrule the expert witness and demonstrate that no other doctor would have behaved in a similar manner.

When calculating liability, the 'Bolam test' can be conceptualised as what medical practice is, as opposed to what it should be. In the superseding case of *Bolitho v City and Hackney Health Authority* (1997), the effects of paternalism and peer review that were evident in *Bolam* were addressed. In the case involving *Bolitho*, a two-year-old boy suffered brain damage when bronchial air passages were blocked, causing a cardiac arrest. The boy later died. A doctor was notified of the boy's deteriorating condition but failed to attend, arguing that if she had attended she would not have intubated him. His family sued the hospital arguing that he would have survived if he had been intubated. Five out of six expert witnesses stated that the child should have been intubated. The claim was dismissed, as causation could not be proven. The precedents set by *Bolitho* saw restrictions to limit the boundaries that *Bolam* had established. It stated that the court could no longer accept a defence for clinical negligence as being 'reasonable or responsible' without subjecting the argument to logical analysis, which must have considered the risks and benefits of all options. The consequences of *Bolitho* are that the law has adopted a more questioning stance in examining medical evidence. The nurse's duty in professional practice remains defined using the principle founded in *Bolitho* (1997) according to Clarke (2015).

Rowe (2005) conceptualises personal accountability as the registered nurse's competence to practise and their conduct during practice. Wachter (2013) raises the emotive question of whether individual accountability should be judged by the individual themselves or by impartial regulators such as peers, patients or the healthcare system that the individual works for. The locus for accountability is difficult to identify as it is heavily influenced by the culture and system management that encapsulates it (Wachter, 2013). Furthermore, Wachter (2013) asserts that although patient safety is at the heart of the healthcare system, it is the very systems and processes designed to protect patients that cause harm to patients, as opposed to individual practitioners. Leonard and Frankel (2010) concur with this viewpoint, adding that healthcare organisations need to adopt a safety culture which addresses failures

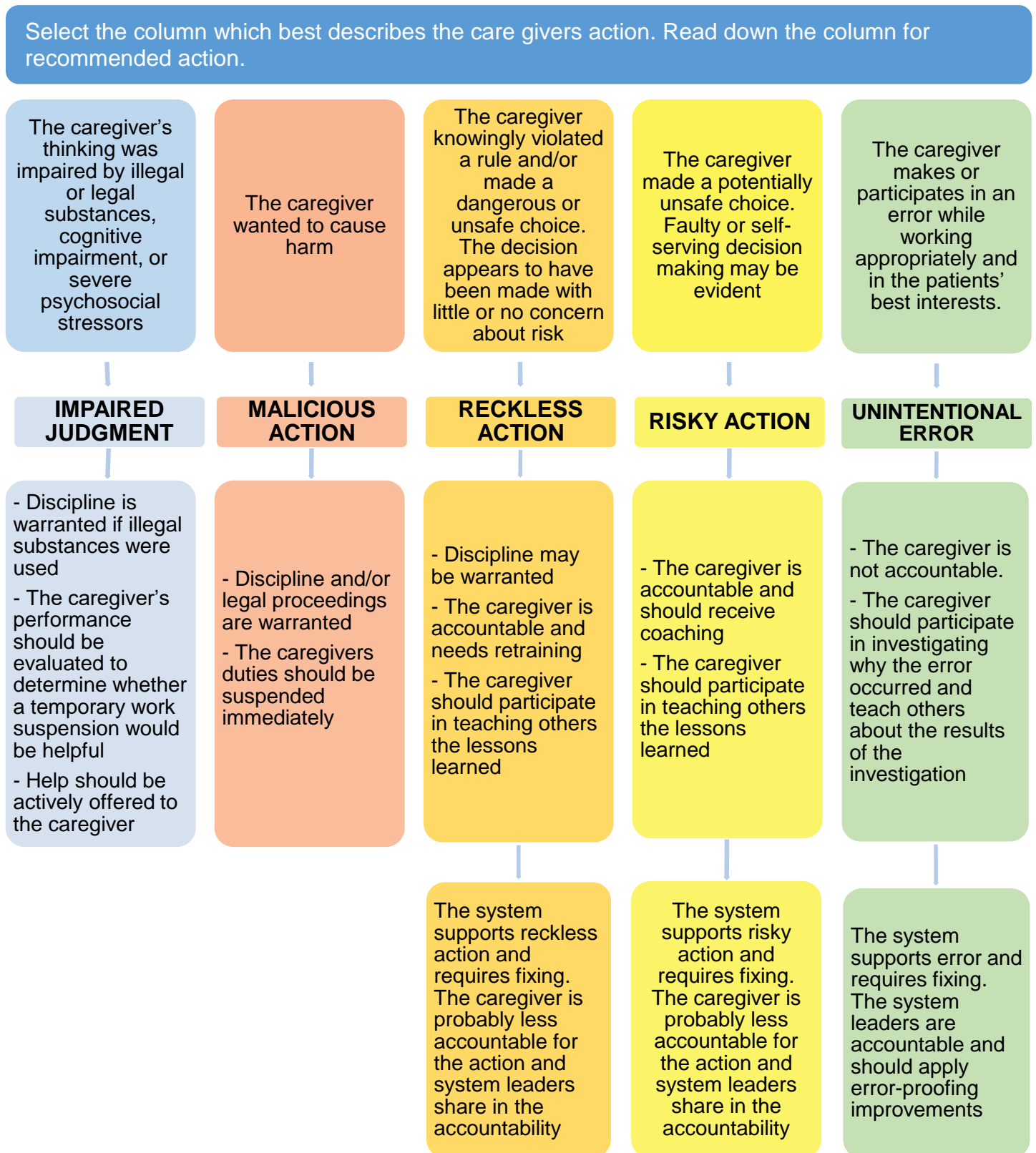
in processes of care and supports staff to report concerns, in order to stop repetitive mistakes from occurring.

The algorithm presented in Table 1 by Leonard and Frankel (2010) is an adaptation taken from Reason's (1997) Unsafe Act Algorithm to determine accountability, by exploring if the act or omission was intentional. The point of this algorithm is to create a culture where everyone is aware of the 'rules', and therefore a more open and just culture can be created, facilitating openness. Frankel et al (2006:1692) offer the following definition:

A Fair and Just Culture is one that learns and improves by openly identifying and examining its own weaknesses. Organizations with a Just Culture are as willing to expose areas of weakness as they are to display areas of excellence.

By eliminating blame for system failures beyond their control, staff feel safe in the open culture in existence, motivating them to sustain the positive environment and deliver quality care to patients (Leonard and Frankel, 2010). Leonard and Frankel's (2010) framework for the creation of a positive culture also centralises the need for effective leadership, which is visible, and engages with healthcare staff.

Table 1: Algorithm by Leonard and Frankel (2010)



Algorithm by Leonard and Frankel (2010): An adaptation of Reason's (1997) Unsafe Act Algorithm and Marx's (2007) Just Culture model, to analyse risk.

The concept of shared governance is also relevant when discussing professional accountability, since it incorporates the principle of establishing cohesive partnerships underpinned by the notion of equality, accountability and ownership (Hess and Swihart, 2013). Shared governance has the potential to empower the healthcare team and increase standards in patient care (Taylor, 2016a:20). The next section looks at nurses' professional accountability to their employing organisation.

Nurses' professional accountability to the organisation

It is acknowledged through registered nurses' compliance to both the NMC code of professional standards (NMC, 2015a) and the employing organisation's contract of employment, that there exists both legal and ethical accountability to the organisation, and to the patients in their care. Indeed, accountability is conceived by Lachman (2008) as an organisational obligation to communicate the rules and standards that exist. Certainly, it has become commonplace that all NHS trusts use local or national guidelines and frameworks to offer practitioners guidance and instruction in all areas of clinical practice. However, Bazerman et al (2011) assert that managers are conditioned to reward results as opposed to good decision making. This point was echoed by Epstein (2009) who notes that organisations judge success or failure on outcome measures linked to rigid descriptors, which do not translate to individual patient need. Epstein (2009) further argues that accountability measures for organisations should have flexibility and variability to take account of patient need. In contrast, healthcare organisations need to view success or harm through quantitative measures and reliability, needing measurable goals in order to obtain this data (Vincent et al, 2014). Bassett and Westmore (2012) comment that if nurses are to be held professionally accountable for their actions, it is essential that there exists clarity on what is considered a 'successful care outcome'.

Organisational responsibilities to employees also exist and these have come into question frequently of late, as high-profile reports have investigated the safety of hospital trusts across the UK. The Care Quality Commission (CQC, 2013a, 2013b) identified various safety issues in hospitals across the UK and actioned special measures for 11 out of the 14 trusts found to be underperforming. The Care Quality

Commission looked at the findings from the Francis report (2013) and the Keogh review (2013b) and made recommendations to increase the vigilance of regulators and supervisory bodies to identify and challenge poor care in both health and social care. It added that responsibility for the standards of care lay with all parties from board members and managers to care staff and commissioners. Watcher (2013) posited the idea of shared accountability by asking if poor care is the result of human failure at an individual level or a systems failure at an institutional level. In the NHS, a system of governance exists to promote high standards in patient care. Clinical governance serves to manage risk, audit care provision and ensure that safe, effective and evidence based care is provided, a subject discussed further in Chapter Two.

Nurses' professional accountability to their regulatory body, the NMC

Background

The term 'profession' has the literal meaning of 'to declare or proclaim publicly', and in creating a profession, individuals declare their commitment to their ideals, behaviours and promises (Pellegrino, 2002). A profession is defined by Freidson (1994) as an occupation that has achieved functional autonomy. In contrast, Calman (1994) offers a more complex description of a profession as being multi-dimensional, consisting of several characteristics such as self-regulating, ethical, providing a service to others, having an up-to-date knowledge base and being accountable to its clients and its own professional body. Historically, it was noted that other professions such as doctors and lawyers, were aligned by their adoption of a code of ethics (Carr, 2000). Indeed, the ethical code was seen as a method of self-regulation and a means of individual identity to the said profession (Meulenbergs et al, 2004). Carr (2000) asserts that the adoption of a code of ethics has been used as a form of leverage in the quest for professionalism. Furthermore, Beauchamp and Childress (2001) comment that the usage of an ethical code serves to clarify the ethical dimensions of a profession. Meulenbergs et al (2004) also argue that the economic, social and technological drivers, which affected health care at this time, meant that nurses needed to adopt a professional status to bridge the disparity between themselves and the medical profession. Professionalism is generally regarded as the portrayal of the qualities and conduct necessary for that particular profession (Pellegrino, 2002). Prior

to the establishment of an accepted ethical code, the Nightingale Pledge was adopted in many countries and served as an inspirational code, dating back to 1893 (Purtillo and Cassell, 1981). The Nightingale Pledge (1849/1946) was designed as an adaptation of the Hippocratic Oath, and seen as the depiction of principles and ethics of nursing (Fowler, 2010). The Pledge is still in use in many countries and includes the vow to 'abstain from whatever is deleterious and mischievous' (Fowler, 2010: xiii). The Nightingale Pledge also advocates that nurses help the medical profession, reinforcing the ideology of servitude and oppression (Yoder-wise, 2013).

In 1953, the International Council of Nurses (ICN) adopted its first official code. The ICN code gave broad guidance on the responsibility of all nurses around the world regardless of national cultures, laws and healthcare systems. It listed the obligations as promotion of health, prevention of disease, restoration to health and the alleviation of suffering. The code also pointed to nurses' duty to show respect for the human rights of all individuals in their care. The European Commission, which oversees the European Federation of Nursing Regulators, set out the 'The Code of Ethics and Conduct for European Nursing' in 2004. This sought to embody the ethical principles held throughout Europe to protect and provide quality care to the citizens of Europe. Oulton (2000) comments that a professional code of conduct affords nurses guidance with ethical decisions and in doing so, facilitates high standards in patient care. As nursing fought for professional status alongside medicine and law, it had to overcome two barriers: firstly, the public's perception of nursing as an occupation of low esteem and secondly, its out-of-date hierarchical structure. By adopting an ethical code, both obstacles could potentially be overcome (Meulenbergs et al, 2004). The ethical code sought to incorporate the principles of deontology, underpinned by the foundations of social values (ICN, 2012). Deontology is a normative ethical stance concerned with duty and looks at the ethics associated with decisions in given situations and adherence to the rules (Beauchamp and Childress, 2001).

The first code of professional conduct published in the UK was in 1983 by the newly created United Kingdom Central Council for Nursing and Midwifery (UKCC, 1983). Its purpose was to establish a system of rules and principles to provide regulation to its members and demonstrate its responsibilities to society (Bandman and Bandman, 1985). Hussey (1996:252) states that codes of conduct offer 'guidance, regulation,

discipline, protection, information and proclamation' to their members. Dobrowolska et al (2007) assert that a professional code provides an essential point of reference, which can be used in decision-making processes central to patient care. However, Hussey (1996:257) argues that ethical codes are both restrictive and prescriptive, viewing this as a method of 'undermining the development ethical sensitivity', which ideally should be the foundation of professional competence. In contrast, González-de Paz et al (2012) assert that codes of conduct support nurses in decision making in situations that present professional dilemmas. Critics of ethical codes see them as too idealistic or abstract to be applicable to practice (Pattison, 2001; Tadd, 2006). Moreover, codes of practice should be viewed in the social and nursing context of the time and should be revised periodically according to Liaschenko and Peter (2004). The code of professional conduct from its conception and first publication in 1983 (UKCC, 1983) was underpinned by the ethical principles of beneficence, non-maleficence, respect for autonomy, fairness, truthfulness and justice (Beauchamp and Childress, 2001). The UKCC's (1992) revised code reflected its earlier versions very closely and charged nurses to 'act at all times in such a manner as to safeguard and promote the interests of individual patients and clients'. This stipulation represented the ethical principle of respect for autonomy and dignity. Secondly, it stated nurses should 'serve the interests of society', referring to the principle of justice and equality.

Lastly, the code looked at the public's trust and confidence in the profession, which also demonstrates truthfulness by adding that nurses 'shall act at all times in such a manner as to justify public trust and confidence' and 'uphold and enhance the good standing of the reputation of the [nursing, midwifery and health visiting] professions'. It can be argued that without public confidence a professional relationship is not viable or workable (Pattison, 2001). Price (2006) refers to the patient centred approach to nursing that focuses on the nurse-patient relationship, which is underpinned by trust. Indeed, Hinchcliffe et al (2008) warn of the vulnerability of patients and the need for nurses to value the trust of patients, since the power balance of the nurse-patient relationship is unequally weighted in the nurse's favour. The code (NMC, 2015a) instructs nurses to safeguard the interests and dignity of patients and clients, irrespective of their gender, age, race, ability, sexual orientation, economic status, lifestyle, culture, and religious and political views, recognising and respecting their role as partners in their own care.

The code: professional standards of practice and behaviour for nurses and midwives (NMC, 2015a)

The Nursing and Midwifery Council charges 690,773 nurses and midwives with professional accountability (NMC, 2017a). *The code: professional standards of practice and behaviour for nurses and midwives* (NMC, 2015a) sets out the responsibilities and duties of care for all nurses. Nurses are expected to fulfil a designated amount of time in their area of practice, keep up to date with research and clinical competencies, along with a record of reflection and feedback in order to dictate their fitness to practise. The most recent NMC code of conduct was published in 2015 and has 115 paragraphs, making it lengthy and challenging for both nurses and the NMC to apply. The new NMC code is described by Pete (2014) as a retrograde step, considering that the Francis report (2013) commended the NMC (2008) code for its simplicity and clarity. The code of professional conduct lies at the very heart of professional accountability as it enshrines the behaviour and responsibilities of every nurse who is registered with the NMC. The NMC code (2015a:4) makes reference to the four priorities of care: to 'prioritise people, practice, safety and professionalism'.

The NMC code (2015a) is designed to conceptualise good care and professional behaviour. It extols the virtues of putting the needs of patients first, protecting their dignity and responding to their concerns, and physical, social and psychological needs. It refers to the necessity of confidentiality, privacy and best interests of those patients in the nurse's care. Furthermore, it enforces the need to deliver evidence based practice, and work effectively within a multi-disciplinary setting. The NMC code (2015a) embodies the concept of providing a safe environment, which requires nurses to be competent in their practice, and open and honest in their behaviour. This component of the code (NMC, 2015a) also mentions the responsibility of nurses in raising concerns about patients, colleagues or the practice environment. The priority of promoting professionalism and trust (NMC, 2015a:15) asserts that nurses should 'uphold the reputation of your profession at all times', by upholding the standards of practice enshrined in the code and acting with integrity and honesty at all times.

Accountability of the NMC

The Nursing and Midwifery Council is the biggest professional regulator in the world (Maxwell, 2016). It is itself regulated by the Professional Standards Authority for Health and Social Care (PSA), created to oversee the nine statutory regulators of healthcare professionals in the UK. The PSA (2013:4) has been highly critical of the NMC, most notably in its failure to meet eight of the 24 'Standards of Good Regulation'. The NMC were also the focus of a strategic government review, which recommended improvements in its delivery of regulatory functions and changes to its governance and operations (CHRE, 2012). The Francis report (2013) describes the profile of the NMC and its channels of communication for staff, stakeholders and patients as poor. Francis QC, goes on to say that the NMC failed to appropriately define its role or responsibilities, and recommended a series of reforms in order to raise the standards of care and compassion in nursing (Francis, 2013). Most notably the Francis report (2013) recommends that a method of revalidation be imposed on all qualified nurses, as well as bringing in a registration and training programme for all healthcare assistants. The Francis report (2013) also makes it clear that the NMC should adopt a more proactive stance to the safety needs of patients, as opposed to its historical reactionary approach, allowing it to investigate systemic concerns as well as individual ones.

In 2015, the PSA reported that the NMC failed to meet seven of the 24 standards of good regulation and performed inconsistently against two other standards (PSA, 2015). In 2017 the health secretary, Jeremy Hunt launched an inquiry into the NMC's handling of the Morecambe Bay investigation (RCM, 2017). The unrelenting criticism of the NMC and the acknowledgement that it may not be fit for purpose (PSA, 2013) has caused the Department of Health to draw up plans to change the regulation process and possibly merge the GMC with the NMC (James, 2017). The establishment of a core regulator could potentially benefit efficiency, accessibility and patient safety, although the financial costs of such an exercise would be excessive (Dancer, 2017).

Summary

Professional accountability conceptualises the practical, legal and ethical constraints surrounding nursing practice and nurses' behaviour. However, the literature suggests there is a lack of clarity as to the definition of professional accountability, despite its wide usage in policy and practice documentation (Krautscheid, 2014). Nonetheless, it is clear nurses have a personal accountability for their own actions and omissions, and for the quality of care they provide. There also exists a professional accountability to the NMC, as well as to their employing organisation. These three elements of professional accountability serve to establish a safe and effective healthcare environment for patients (NMC, 2015a). However, there is evidence to suggest that accountability in the NHS is seen as sanction based as opposed to being based upon trust (Mansbridge, 2014). This draws attention to the importance of good management and leadership within the NHS and the current failings that are apparent. There are also questions around the suitability of the NMC when the regulator itself is being held to account for its own fitness to practise (PSA, 2013, 2015). Nurses are held accountable to the NHS and the NMC, yet both organisations are failing in their own accountability regarding patient safety, through poor governance and ineffective management. There is also evidence to suggest that professional accountability is influenced by the culture of nursing and the changing nature of clinical practice, in terms of responsibility and delegation. Accountability is a concept extremely pertinent in contemporary healthcare, as the NHS faces immense challenges in care delivery (Charles, 2018). In light of the evidence presented in this opening chapter, I now present the aims of this study.

Aims of this study

The overarching aim of this study is to explore professional accountability in nursing. The first chapter has served to define professional accountability and has begun to outline some of the challenges evident for the nursing profession. This study therefore explores the *lifeworld* of the nurse, in relation to their professional accountability within the context of working in the NHS. The work is grounded in the hermeneutic philosophy of Martin Heidegger. I attempt to elucidate and clarify the complicated and at times seemingly impenetrable vocabulary of Heidegger (1927/2010) to argue the importance of this methodology to nursing research. I also demonstrate the synergy that exists between hermeneutics and the humanistic and holistic values of nursing. Heidegger's (1927/2010) philosophy has often been misunderstood, and the gravity of his existential questioning overlooked. This study tries to unpick and unravel the poignant theories of Heidegger's (1927/2010) work and use them to explore the nurse's *lifeworld* through the participant's experience, as they perceive it. Using an interpretive design, I investigate how registered nurses experience *being* a nurse and look at the cultural, historical and political contexts that influence their professional accountability and patient care delivery. Benner (1985) notes that by studying an individual's experience as it is lived we are able to understand the ways in which situations are encountered as regards their concerns, background understandings and purposes. Benner (1994) also observes that our understanding is sometimes covered up by our everyday practices yet can be disclosed through description and interpretation. This interpretation of another's experience has aimed to provide understanding to the meaning of *being* a nurse in terms of professional accountability.

The aims of this Heideggerian hermeneutical investigation are as follows:

- To explore the *lifeworld* of the nurse as it relates to professional accountability.
- To explore factors that influence nursing practice and individual accountability in practice.
- To explore the impacts of nurses' professional accountability on patient care.
- To add to the existing body of knowledge and develop insights to inform future practice, thinking, research and education.

To put these aims into the context of my personal biography, a little background into my own experience may be valuable to the reader. As a nurse with many years' experience, I have always been inspired to improve practice and support other nurses. As a specialist practitioner in community nursing, I was awarded the title of Queens Nurse for my commitment to promoting high quality care for patients. However, the nursing profession is often heavily criticised by the media and branded as uncaring and indifferent to the incidents of poor care witnessed within healthcare settings. Poor care is inexcusable, as is low staffing and an unwillingness to make changes when concerns are raised. The prevailing culture of nursing has often left me feeling disillusioned by what does occur in nursing practice, in contrast to what should occur. This disparity in values has made me question my own professional accountability to patients, colleagues, the organisation and nursing's regulatory body. As members of a profession, nurses have a code of conduct, which is sometimes at odds with their experiences in clinical practice, when inadequate resources and a negative culture mean they are unable to give the holistic care their own professional standards demand. As a clinical practitioner, I have experienced this at first hand and felt the stress, fatigue and frustration that come with it. I therefore set out to investigate how registered nurses experience their own professional accountability, to understand what this concept means to them and how this impacts upon patient care provision. In order to contextualise this study within the participant's environment, it would be useful to explore the history and development of the UK National Health Service (NHS). The rationale for this next chapter allows the reader an insight into the challenges the NHS faces, and the failures in healthcare that have questioned the ideals of professional accountability in nursing.

Chapter Two: The National Health Service (NHS) in the UK

Overview

This chapter details the structure of the National Health Service in the United Kingdom and look at the historical and cultural influences that impact upon the organisation as a whole, and the healthcare it provides. The NHS has provided the backdrop to this study, as it is the environment in which participants of this study work. This chapter highlights the publications of many high-profile investigations over the last 15 years. These influential inquiries uncovered damning evidence of systematic healthcare failings and the existence of a negative culture, inadequate staffing levels, systems failures and the lack of effective management and leadership. These findings are intrinsically linked to nursing practice and to the concept of professional accountability, as they compromise nurses' ability to meet the professional standards of practice and behaviour set out in the NMC code (NMC, 2015a). The fundamental issues discussed by these reports bring into question the degree to which the ideals enshrined within professional accountability have, in reality, impacted upon patient care. I now present the commonalities apparent within these reports to allow the reader to appreciate some of the failings, which are evident within many healthcare settings, and the complex nature of contemporary nursing.

Background

The National Health Service was created in 1948 and promised equitable and quality health care for all, which would be free at the point of access. The values, purpose, and principles of the National Health Service in the United Kingdom were enshrined in the NHS Constitution and designed as a 10-year plan to increase the quality of patient care. The Constitution was first published in 2009 and was a recommendation from Lord Darzi's report, *High quality care for all* (DH, 2008). The constitution lays down the rights and responsibilities patients, public and staff are entitled to receive. The future commitments to service delivery are conceptualised as a series of pledges. Furthermore, the Constitution outlines the rights surrounding access to healthcare services, namely the fact that access will be free at the point of entry and never refused on reasonable grounds and will not be discriminatory. It also states that the NHS will provide community services to meet the needs of those it serves. In addition, patients

have the right to access commissioned services within maximum waiting times or be offered reasonable alternative services. The Handbook to the NHS Constitution presents its commitment to deliver easy access to services, clear and transparent decisions, and the provision of a smooth continuum of care between services.

Safety and quality of care in the NHS are monitored through its clinical governance, through clinical effectiveness, clinical audit, research and development, risk and information governance and professional development of staff. Clinical governance was introduced in 1997 following the government white paper entitled *the new NHS: modern, dependable* (DH, 1997), which was closely followed by *Quality in the new NHS* (DH, 1998). The concept of clinical governance was to establish a framework that would address the disparity in the quality of care being experienced across the country. By establishing a quality focused agenda, the new policy aspired to encourage clinical excellence and promote equity and uniformity of service provision. The six principles of clinical governance are listed below:

1. To re-establish the NHS as a national service for all patients throughout the country, where patients will receive high quality care regardless of age, gender or culture if they are ill or injured.
2. To establish national standards based upon best practices, which will be influenced and delivered locally by the healthcare professionals themselves, taking into account the needs of the local population.
3. Collaborative working partnerships between hospitals, community services and local authorities, where the patient is the central focus.
4. To ensure that the healthcare services are delivering high quality care and providing value for money.
5. To establish an internal culture where clinical quality is guaranteed for all patients.
6. To enhance public confidence in the NHS (DH, 1997).

Clinical governance highlights the clinician's individual responsibilities to engage with life-long learning to increase the quality of care for patients and identify any incidence of poor professional practice. Bassett and Westmore (2012) add that for the principles of governance to be successful there needs to be an effective leadership team that ensures a positive culture to support accountability and decision making. The Department of Health Performance Framework (DH, 2009) followed this and introduced minimum standards to assess the performance of NHS providers and commissioners. The five principles that underpin the performance framework are transparency, consistency, proactive, proportionate and focused on recovery. The performance framework measures quality and safety and relates these to patient experience as well as operational effectiveness. Also, in 2009, the NHS Operating Framework was introduced, using a national performance dashboard, which could support both local and national target setting and generate comparison data. The National Quality Board recommended the establishment of defence systems, which would protect and assure the public against failures in health care (Nicholson, 2012).

The issue of professional accountability in clinical governance is an important one in relation to operational performance. On an individual basis, nurses remain accountable for their personal behaviour regarding care provision under legal constraints, the NMC code of practice (NMC, 2015a) and national and local policy guidelines. However, under the framework of clinical governance, groups of professionals are also accountable for one another's performance, allowing for collective accountability. Accountability can therefore be depicted as being individual, horizontal, top down and bottom up. Veenstra et al (2016) carried out a Delphi study and made recommendations for practice, suggesting that a bottom-up approach to the governance of healthcare would be a more effective method. Balding (2008) concurs with this, commenting that since clinical practitioners would be best positioned to uphold and improve clinical standards, a bottom-up approach to clinical governance would value their experience and expertise. However, the current system of clinical governance appears to reflect a top-down approach (Balding, 2008), which exacerbates a culture that incorporates blame (Berwick, 2013).

Failures in healthcare

The NHS in the UK has witnessed myriad failures in healthcare delivery, which has affected countless individuals and involved untold numbers of preventable deaths. Reports stretching back to 1969 detailing failings at Ely Hospital to more recent reports at Mid Staffordshire (Francis, 2013), Morecambe Bay (Kirkup, 2015) and Southern Health (Mazars, 2016) have all had common links, and each has repeated the need for the NHS to make changes to its culture and focus on patient safety. Other recurrent themes have been staffing levels, effective reporting systems and effective leadership. Despite calls for the NHS to learn from its mistakes, there seems to be a repetitive cycle of errors which have immense costs in terms of human suffering, as well as in monetary terms. Below is a table charting some of the high-profile government investigations over the last 15 years. This timeframe has been selected to keep the focus contemporary. The list is by no means an exhaustive compilation but is intended to draw together some of the most significant failures, along with brief notes detailing the contributory factors. It is important to outline these investigations, as the specific failings have direct associations to nurses' professional accountability. In the majority of these reports there is mention of inadequate staffing, poor governance and lack of leadership which, as discussed previously, inherently compromise nursing practice.

Table 2: Government investigations into NHS hospital trusts

| Investigation | Year | Main failings |
|-------------------------------------------------------------------------------------------------------------------|------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Maternity services by Royal Wolverhampton Hospitals NHS Trust | 2004 | <ul style="list-style-type: none"> • Weak risk management and poor reporting of incidents and handling of complaints. • Poor working relationships and poor working in multidisciplinary teams. • Inadequate training and supervision of clinical staff. • Poor facilities and services isolated. • Shortages of staff coupled with poor management of temporary employees. |
| Mid Yorkshire Hospitals NHS Trust | 2004 | <ul style="list-style-type: none"> • Systemic management failings, from the most senior level down. • Failures in governance. |
| Drug dependency services at Bolton, Salford and Trafford | 2005 | <ul style="list-style-type: none"> • Inadequate reporting and investigating system. |
| Maternity services by North West London Hospitals NHS Trust | 2005 | <ul style="list-style-type: none"> • Weak risk management with poor reporting of incidents and handling of complaints. • Poor working relationships and poor working in multidisciplinary teams. • Inadequate training and supervision of clinical staff. • Poor facilities and services isolated geographically or clinically. • Shortages of staff coupled with poor management of temporary employees. |
| Allegations of bullying and harassment at Devon Partnership NHS Trust | 2006 | <ul style="list-style-type: none"> • Bullying and harassment by managers. • Insensitive complaint handling by managers. • Poor human resource dept. |
| Allegations of bullying and harassment and the process for handling complaints at East Sussex Hospitals NHS Trust | 2006 | <ul style="list-style-type: none"> • Bullying and harassment by managers. • Negative management culture. |
| Investigation into Mid Cheshire Hospitals NHS Trust | 2006 | <ul style="list-style-type: none"> • Poor leadership. • Low staffing levels. • Poor support for clinicians. |

| Investigation | Year | Main Failings |
|-----------------------------------------------------------------------------------------------------------------------------|------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Investigation into service provision for people with learning disabilities at Cornwall Partnership NHS Trust | 2006 | <ul style="list-style-type: none"> • Serious flaws in safeguarding adults. • Senior managers failed to identify and correct situations involving abuse. |
| Investigation into outbreaks of clostridium difficile at Stoke Mandeville Hospital, Buckinghamshire Hospitals NHS Trust | 2006 | <ul style="list-style-type: none"> • Poor infection control. • Poor leadership. |
| Investigation into maternity services, North West London Hospitals | 2006 | <ul style="list-style-type: none"> • Weak risk management with poor reporting of incidents and handling of complaints. • Poor working relationships and poor working in multidisciplinary teams. • Inadequate training and supervision of clinical staff. • Poor facilities and services isolated geographically or clinically. • Shortages of staff coupled with poor management of temporary employees. |
| Investigation into service provision for people with learning disabilities provided by Sutton and Merton Primary Care Trust | 2007 | <ul style="list-style-type: none"> • Outmoded care for people with learning disabilities. • Inadequate training for staff. • Inadequate support for staff. • Poor staffing levels. |
| Investigation into cardiothoracic surgical services at Oxford Radcliffe Hospitals NHS Trust | 2007 | <ul style="list-style-type: none"> • Poor use of mortality data. |
| Investigation into service provision for people with learning disabilities: Winterbourne view | 2012 | <ul style="list-style-type: none"> • Negative culture. • Poor leadership. • Inadequate training for staff. • Inadequate support for staff. • Poor staffing levels. • Inadequate reporting systems/ systems failures. |
| Investigation into poor standards of care and high mortality rates: Mid Staffs NHS Trust (Francis report) | 2013 | <ul style="list-style-type: none"> • Inadequate staffing. • Culture of bullying. • Poor leadership. • Inadequate reporting systems. |

| Investigation | Year | Main failings |
|----------------------------------------------------------------------------------------------------------------|------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Keogh Review 'Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England' | 2013 | <ul style="list-style-type: none"> • Variable staffing levels in hospitals at the weekend. • Absence of consultants at weekends. • Lack of consistent specialist services at weekends. • Lack of specialist community and primary care services. • Lack of leadership. • Negative culture. • Inadequacies in reporting system. |
| Berwick Review 'Improving the Safety of Patients in England' | 2013 | <ul style="list-style-type: none"> • Failures in governance. • Failures in leadership. • Blame culture. • Lack of transparency. • Failures in reporting systems. • Inadequate staffing. • Lack of support for staff. |
| High mortality in maternity services: Morecombe Bay NHS Trust (Kirkup report) | 2015 | <ul style="list-style-type: none"> • Negative culture. • Inadequate reporting systems. • Poor leadership. • Inadequate training for clinical staff. |
| High mortality of people with a learning disability and mental health problems: Southern Health NHS Foundation | 2016 | <ul style="list-style-type: none"> • Negative culture. • Failures in investigating deaths. • Families and carers' involvement limited. • Lack of leadership. • Lack of transparency. • Lack of specialist training for staff. |

Many of the trusts investigated were involved in restructures or mergers and were focused on addressing financial pressures and targets. There was often a lack of leadership and continuity in leadership, which resulted in a loss of strategic planning and poor governance (CQC, 2016). The overriding miscalculation was in not putting the patient first. Moreover, leadership has been a theme in many government health plans throughout the history of the NHS and as such has been recognised as an integral attribute in making the NHS a safe environment for patients and staff alike. Yet effective leadership in the NHS seems elusive, since poor leadership continues to be at the heart of many of these catastrophic failures in healthcare provision.

Professor Berwick, an international expert in patient safety was appointed to carry out a review of patient safety across the NHS in 2013. The Berwick review (2013) recommended systemic changes to the culture of the NHS, putting an end to blaming staff and instead recognising the positive attributes of staff, acknowledging that in the vast majority of incidents, the problems stem from failures in procedures and systems. Furthermore, it called for an open and transparent way of working; putting patient centred care at the heart of healthcare, along with recognition that quantitative targets should be used with caution, as opposed to being the driving force (Berwick, 2013). In his recommendations for candour, he emphasised that this should be embedded within a new culture of safety and improvement. Another key issue from the Berwick review (2013) was the need for clear and effective leadership throughout the organisation. He also highlighted the need to learn lessons from government investigations and have a resolute obligation to change.

Many of the reports listed above document how the NHS trusts involved had failed to protect patients from avoidable harm and in many cases had deprived them of their basic human rights. Francis (2013) drew reference to the NHS Constitution throughout his report pointing out that this should underpin all healthcare provision and its ethos inform all clinical practice. The investigations at the Cornwall Partnership (2006), Merton and Sutton (2007) Southern Health (2016) and Winterbourne View (2012) all detailed the ongoing tolerance of poor standards in patient care, inadequate staffing and lack of specialist training for staff. Furthermore, they acknowledged the general loss of primary mission parameters, which applied to the most basic need to provide safe, compassionate care. The reports into the avoidable harm and deaths in maternity care at Royal Wolverhampton Hospitals (2004), North-west London (2005), West London Hospitals (2006) and Morecambe Bay (2015) detailed serious failures in clinical care resulting in avoidable harm to mothers and babies, and in some cases deaths. Again, the investigations revealed the inability to recognise the ongoing failures within the healthcare system, which meant that mistakes continued, as did more avoidable fatalities. Repeatedly, the reports identified clinical competence, skills and knowledge of staff as being attributable, along with a negative culture that prevailed.

Many of the highlighted government investigations found that the reporting systems had failed and concerns were not addressed, allowing mistakes to be repeated resulting in a failure to learn any lessons to improve practice. In the Francis report (2013) and the Kirkup report (2015) there were detailed failures at all levels of the NHS, from clinical practice to the regulatory bodies. The Francis report (2013) made direct and indirect criticism of the NMC and recommended the introduction of a more robust system for public protection in terms of revalidation comparable to the GMC. Recommendations were made with a view to raising competencies and professional standards of qualified nurses, with an emphasis on the importance of professional development. The Francis report (2013) also suggested changes to recruitment with the introduction of aptitude tests to measure professional values in pre-registration candidates and an emphasis on practical skills being taught. The ethos underpinning all these measures was to facilitate a more caring and compassionate workforce, who strive for high standards in patient care. The NMC made an official response to the Francis report (NMC, 2013) and publicly resolved to learn lessons from the inquiry and sanctioned the *Statement of common purpose* (NMC, 2013). The actions formulated by the NMC included a review of the *Code of conduct* (NMC, 2008) and strategies aimed at public protection. It also made recommendations regarding pre-registration training and an evaluation of processes and legislation. There were also actions to facilitate changes around information sharing and the need to create a proportionate revalidation model. This culminated in the new NMC code of conduct in 2015 (NMC, 2015a) and the revalidation programme, which commenced in April 2016 (NMC, 2015a).

The prevailing culture of the organisation, often specifically linked to the culture of nursing, is a subject that has received attention in many of the government investigations over the past 15 years. It is described by Berwick (2013:4) as a toxic culture of fear and blame. These negative descriptions of culture permeate through many of the reports and are often cited as justifications for poor standards of care and for not reporting the presenting problems in care provision. Francis (2013) made many broad references about the culture of nursing, describing it as defensive and adding that it was not open to receive criticism. The Kirkup report (2015) asserted that midwives became unable to raise concerns because they had previously denied

anything was wrong regarding the safety of patients, creating a closed and protective culture (Kirkup, 2015). These failings are also echoed in other reports.

The investigations detailed in this chapter highlight the failings in the NHS and the existence of a negative culture within the organisation, specifically amongst nurses. The reports all found evidence of failures in operational procedures and systems. The consequences mean that concerns were not addressed and sub-standard care for patients was allowed to continue. In short, the principles of clinical governance failed at every level, jeopardising patient safety and resulting in avoidable harm and even deaths. The majority of the reports cited ineffective and poor leadership as contributing factors. Evidence from the Kirkup report (2015), Francis report (2013) and PSA (2015) suggested poor regulation from the NMC, concluding that it was 'not fit for purpose'. The collective recommendations from all the aforementioned investigations called for systemic changes across the NHS, with an emphasis on putting the patient first. Berwick (2013) called for a new culture of safety and openness that values staff and eliminates blame, a point echoed by Keogh (2013a, 2013b).

The first two chapters of this thesis have provided a contextual background into professional accountability, and the complex challenges evident within the NHS. By looking at healthcare failings over many years, it is clear that professional accountability has the potential to be influenced and compromised by numerous external factors. A negative culture fuelled by blame has been highlighted in several of the reports, and results in nurses' reticence in raising concerns and the perpetuation of incivility. It seems the root cause of many of the problems present in both nursing and healthcare are intrinsically linked to effective leadership and adequate staffing. Positive changes in nursing leadership and staffing levels could have beneficial effects upon patient care and the practice environment, thus increasing nurse retention (Twigg and McCullough, 2014). If patient safety is embedded as an essential component of healthcare (CQC, 2016), then nurse safety, as regards nursing incivility and the working environment, should have equal priority. As nursing shortages and NHS pressures build, the need for staff retention and nurse recruitment to increase is greater than ever (Nuffield Trust, 2015). In exploring the concept of professional accountability, this research study endeavours to look at the contextual influences apparent in the *lifeworld* of the nurse. In utilising a Heideggerian hermeneutical

approach I aim to furnish the reader with a different perspective on an issue of paramount importance in the current healthcare environment.

Chapter Three: The Research Approach

Overview

Chapter Three provides a discussion around the selected research approach of Heideggerian hermeneutics and its ontological and epistemological foundations. The work of Husserl (1901/1970) and Heidegger (1927/2010) are both discussed, allowing the reader to gain an appreciation of the differences and commonalities of these two branches of phenomenology. This chapter also looks at how phenomenology has been used in nursing research, and the apparent synergy.

Introduction

The ontological focus of this study is concerned with what it means *to be* a nurse, with regard to the participants' feelings and perceptions of professional accountability. Drawing reference to the issues presented in Chapter Two relating to the NHS, this study seeks to explore the participants' own thoughts and feelings about working in this environment and the impact upon patient care. As a registered nurse, I have encountered many challenges whilst working in the NHS, as a clinical practitioner and clinical nurse manager. Having had the experience of 'walking the walk', so to speak, I have a genuine interest in researching this area, and exploring how other nurses have experienced professional accountability.

From an epistemological stance, the choice of research design needed to adopt an interpretative stance in an effort to understand people's values, beliefs, feelings and actions within their own environment (Polit and Beck, 2009). Critics suggest qualitative approaches can be unscientific, lacking rigour with findings that are not generalisable (Mays and Pope, 1995; Kohlbacher, 2006). Moule and Goodman (2009), however, contend that qualitative research is interactive, inductive and holistic, and utilises a variety of data collection and analysis methods, making it a flexible, open and responsive approach. Since qualitative research primarily focuses on social enquiry, human behaviour, feelings and experiences, it allows the researcher to deliver rich experiential data (Polit and Beck, 2009). Parahoo (2006) posits that this type of approach allows the researcher to explore individuals' perceptions, motivations and

understandings. In the qualitative paradigm, the emphasis is on technique and process, such as in-depth interviews, focus groups and participant observation. Since qualitative studies involve small purposeful samples, findings are not intended to be representative of a larger group or population (Reid, 1996). It is also argued that qualitative research is more compatible with the philosophical underpinnings of nursing, as it is a humanistic and holistic profession, which values individual experience and holism (Munhall, 1982). Since this study aims to investigate nurses' perceptions of professional accountability, the chosen paradigm must be one that is able to explore the complexity of human experience. Using a qualitative research approach allows focus on the ways in which individuals interpret and make sense of their experiences and the world in which they live. Furthermore, an interpretive approach can provide insights into unique human perspectives and the ability to uncover new meanings, as well as affording coherency to the data.

The philosophy that underpins this study is based upon the work of Martin Heidegger, known as hermeneutics. Hermeneutics is a qualitative research methodology that developed from phenomenological philosophy. This chapter endeavours to clarify the history and background of phenomenology, before embarking on a more detailed portrayal of Heidegger's (1927/2010) work. Heidegger (1927/2010) himself defines phenomenology primarily as a method, with the task being to question what it is to be in the everyday world. Looking for the taken-for-granted and essential understandings masked in our everyday living, we are able to see different perspectives through the lens of the researcher's preunderstandings (van Manen, 1990). The following quotation from Heidegger (1927/2010) perhaps sums this up:

To let that which shows itself be seen from itself in the very way in which it shows itself from itself. (Heidegger, 1927/2010:32)

Phenomenology

Philosophical phenomenology is considered to be the study of structures of consciousness as experienced by the individual (Smith, 2008), allowing meaningful interpretation of individuals' experience and actions (Denzin and Lincoln, 2003). Phenomenology 'examines how the world is experienced' (Taylor and Bogdan,

1984:3) and according to Merleau-Ponty (1964), human experience as it is lived. The overall aim of this approach is to uncover the essential meanings of the individual's experience in the world. Omery (1983) perhaps best sums up this approach when she states:

The phenomenological method is an inductive, descriptive research method. The task of the method is to investigate and describe all phenomena, including human experience in the way these phenomena appear. (Omery 1983:50)

Phenomenology is described by Hallett (1995:55) as a 'complex and controversial' qualitative research approach, and I think it is an entirely accurate point to make, for it is at first glance a very complicated set of beliefs, enveloped by terminology that is alien to the reader. I first deal with the eidetic work of Husserl (1901/1990), who laid the foundations for Heidegger's (1927/2010) work. Indeed, researchers are often criticised for failing to exercise separation from the various philosophical phenomenological frameworks and believing phenomenology and hermeneutics are the same thing (Annells, 1996). I agree this would be a most basic error, and I endeavour to explain and differentiate these two philosophical traditions to accentuate this point.

Phenomenology was developed by Husserl (1901/1970) in the twentieth century and is both a philosophical movement and an approach to human science research (van Manen, 1997). It is founded within the humanistic research paradigm and follows a qualitative approach (Denscombe, 2003). Husserl (1901/1970) defines it as the study of structures of consciousness and experience, as experienced by the first person. Interestingly, the word phenomenology is derived from the Greek word *phainómenon*, which means 'that which appears', and the word *lógos*, meaning 'study'. In epistemological terms, phenomenological inquiry seeks to describe the forms of knowledge and ways of knowing that guide our actions. Merleau-Ponty (1996) describes phenomenology as a philosophical study of essences and their meanings, such as the essence of consciousness. Furthermore, Husserl (1901/1970) offers a transcendental approach to enquiry, which accepts the existence of the world as 'already there', and describes the world as an 'inalienable presence'. In practical terms this approach looks for meanings embedded in the text, allowing cognitive, conceptual,

informative and formative dimensions contained within the text to be seen (van Manen, 1997). It also establishes an embodied understanding of the first person's experience and consciousness. However, phenomenology does not intend to merely provide information or fact; instead it seeks to offer knowledge that is formative in nature, to allow us to increase our understanding and perceptions of experiences embedded in life practices.

Edmund Husserl (1859–1938)

Edmund Husserl was a German philosopher and mathematician. Husserl (1901/1970) was a student of Franz Brentano (1838–1917), who provided the basis for phenomenology. Brentano (1874/1995:88) theorised about the “*intentional nature of consciousness*” or the “*internal experience of being conscious of something*”. However, Husserl (1901/1970) was also influenced by the work of Descartes, which views man's situation as a subject, confronted by objects and the theory of the search for knowledge pertaining to this notion. In proposing *Cogito ergo sum*, translated as ‘I think, therefore I am’, Descartes establishes that the ‘truth of the world is in the mind, not the world itself’ (Taylor, 2009:1). In developing his work, Husserl (1901/1970) also considered naturalism, a belief that posits that all things belong to the world of nature and consequently can be studied using a scientific approach. It was, however, the work of Kant and Hegel that would most closely influence and lay the foundations for Husserl's (1901/1970) concept of phenomenology.

Contextually, Husserl's (1901/1970) ideas lay against a backdrop of war torn Europe, which had felt the full horror of war, both in terms of human suffering and a disembodiment of the arts and philosophy. Eagleton (1996:58) said Husserl (1901/1970) had endeavoured to create ‘a new philosophical method which would lend absolute certainty to a disintegrating civilization’. Husserl's (1901/1970) epistemological beliefs were that human phenomena could not be studied using the experimental scientific research available to him, as it was detached from human enquiry and was starting to obscure the very essence of human experience. This basic ideology led him to develop phenomenological enquiry (Crotty, 1996). Husserl (1901/1970) did not want to be limited to empiricism, a philosophy of science that

theorises that knowledge is derived solely from sensory experience to form ideas. Certainly, empiricism disputes the notion of tradition, claiming that tradition and custom occur from past sensory experiences. This scientific methodology asserts that all hypotheses and theories must be tested against observations of the natural world, and commonly utilises a quantitative design. In contrast, Husserl (1901/1970) believed the study of consciousness was very different from the study of nature. He reasoned that insight was not acquired from large amounts of data, but instead emerged from intense study of experiences, gained from a phenomenological method of research. Husserl (1901/1970) did not deny the existence of the real world, but instead endeavoured to clarify the sense of the real world as actually existing. He discarded the belief that objects in the external world exist independently and believed that the information we perceive about objects is unreliable. Furthermore, Husserl (1901/1970) claimed that individuals can only be certain about how things appear to their consciousness and must therefore ignore all things outside their immediate experience.

Using this theory, Husserl (1901/1970) argued that the external world can be reduced to the contents of personal consciousness. He then went on to add that realities were the pure phenomena and the only absolute data to start with, summed up by the phrase 'back to the things themselves' (Husserl 1901/1970:168). To Husserl (1901/1970:168) 'back to the things themselves' meant that we should go back to the way's things are actually given in experience. To that aim, he reduced the experience of the individual to the term 'sphere of oneness' from which he theorised the existence of the 'impossibility of solipsism.' The term solipsism is a philosophical theory that the self is the only true reality in life and consequently only the self exists. For Husserl (1901/1970), its epistemology centred on searching for meaning, as opposed to arguing a point or developing an abstract theory (van Manen, 1997). Indeed, it is observed that knowledge can only be discovered by 'sharing common meaning of mutual history, culture and language of the world', thereby concluding there are two types of meaning: cognitive and non-cognitive (Flood, 2010:7).

Descriptive (eidetic) phenomenology

An introduction to phenomenology was found in the philosophical work of Edmund Husserl, entitled *Logische Untersuchungen* (Logical Investigations, 1901/1970).

Indeed, Moran (2005) describes Husserl (1913/1998) as both a phenomenologist and transcendental philosopher. As a mathematician he believed that experimental scientific research could not be used to understand human experience, and so introduced the study of the *lifeworld*. His intention was to develop a philosophical theory that could find truth in experience, as it is lived, developing insights from the perspectives of the individuals involved (LoBiondo-Wood and Haber, 2002). Husserl (1913/1989) used this notion to convey the idea that the individual's reality is influenced by the world in which they live, but that it is not easily accessible due to the fact that it encompasses those things taken for granted and considered as common sense. Leonard (1994) observes that a person's *lifeworld* contains their subjective experience and is inextricably linked to its cultural, political and social contexts. This concept of *lifeworld* was a radical step for Husserl (1913/1989) and was influenced by both Heidegger's (1927/2010) *being-in-the-world* and Dilthey's 'life-nexus'. Husserl's (1913/1989) work had previously focused on consciousness using phenomenological reduction. In contrast, the concept of *lifeworld* recognised that consciousness was already present and embedded in the world. Husserl (1913/1989) believed there were commonalities and characteristics to a phenomenon, which were shared by all persons who experienced it; these he referred to as universal essences (Natanson, 1973). My personal view on this theory is that different people can share the same experience, but their views, thoughts and feelings of the event are internalised very differently, again depending upon their individual beliefs, culture and history. Campbell (2001) concurs with this. Further assumptions are made by Husserlian phenomenology; one being the existence of 'radical autonomy', a belief that individual freedom of choice is not impacted by culture, society or politics; instead individuals are responsible for influencing their own environment and culture (Cohen and Omery, 1994).

Husserl's (1913/1989) philosophical method of enquiry gave rise to a descriptive phenomenological approach, believing that subjective information is important in understanding human motivation, since people's actions are influenced by their perceptions of reality. He believed that this lived experience is not freely accessible because it encompasses those things that are taken for granted in our everyday world. Therefore, the intention was to return to those everyday experiences and re-examine them. Husserl (1913/1989) held that phenomenology was the universal foundation of

the philosophy of science, concerned with the fundamental nature of reality (Cohen, 1987). It is asserted by Dreyfus and Dreyfus (1987) that Husserl (1913/1989) sought to reveal the ultimate structures of the consciousness in order to evaluate the roles of these structures in determining the meaning of it all. Husserl (1913/1989:149) added a warning to all potential students studying his work, proclaiming that there is 'no royal road into phenomenology' and the journey will be difficult, because much of the information is new and the path untrodden.

Husserl's (1913/1989:5) central aim in phenomenology was 'getting back to the things themselves'. He called this practice 'intentionality'. We are reminded that consciousness is always consciousness about something, since we are never conscious about nothing. Therefore, intentionality is the directedness of the mind towards objects. In practical terms, the researcher starts to study 'particulars' and continues using inductive reasoning to reach an understanding of 'universal truths' or first principles, thus illustrating that they are studying phenomena as they appear to our consciousness. Husserl (1913/1989) saw consciousness in two ways, the obvious and the enigmatic, in terms of *Noesis* and *Noema*. *Noesis* means the intrinsic and the inherent in the mental process i.e., I am conscious of something and I recognise it. Whereas *Noema* means the perception, as it is perceived i.e., the way I relate to it. *Noema* comes from the Greek word meaning 'thought' or 'what is thought about'. Husserl (1913/1989) used the example of seeing a red apple tree. I have experience of the red apple tree, so there is intentionality present. The *Noema* refers to the way in which I relate to the red apple tree in consciousness, and the *Noesis* relates to the inherent part of consciousness, in the experience of seeing the red apple tree.

This leads onto Husserl's (1913/1989) notion of 'essences', which are described by Koch (1995) as the ultimate structure of consciousness. This put simply, means to go back to the immediate experience, and describe the essences that create the consciousness and perceptions of our *lifeworld*. In order to go back to that immediate experience, we utilise the approach that Husserl (1913/1989) terms bracketing or eidetic reduction. Husserlian phenomenology requires the researcher to suspend their own beliefs, preconceptions and prior knowledge of the phenomena to be studied, so they do not influence the participant's experience (Parahoo, 2006). The process of bracketing, or eidetic reduction, requires the researcher to recognise their

preconceptions, thoughts and experiences of the phenomena, before consciously putting them aside, to prevent them clouding the research process. In this way, Husserl (1913/1989) believed that the investigation would become pure, devoid of previously held ideas. Le Vasseur (2003) observes that bracketing seeks to prevent bias and ensure scientific rigour.

The ultimate aim for the researcher is to attain the Husserlian concept of 'transcendental subjectivity', which involves the researcher constantly assessing their own influence and neutralising any bias (Lopez and Willis, 2004). This concept of eidetic reduction may herald from the ideas of Descartes and the Cartesian tradition, termed 'rationalism'. Rationalism asserts that the prerequisite to studying anything must be the purification of the mind, and emptying it of all extraneous thoughts, which may suppress the learning process. It is the very process of attempting to remove ideas of context, experience and situation that may prove challenging for many researchers. Certainly, I personally found this concept was a difficult one to fully embrace. The idea of being able to separate oneself from one's beliefs and experiences in order to remove any bias was not, I considered, to be of value to me as a researcher, as I wished myself to be heard and understood. I also recognised that as a nurse I was studying members of a group to which I belonged and had professional affiliation with, a viewpoint shared by Edwards (2002). Certainly, Heideggerian phenomenology believes people are inextricably situated in their worlds and it is not possible to bracket or suspend one's own pre-existing experience and understanding (Maggs-Rapport, 2000). I concluded, therefore, that as a researcher I needed to reflect upon my own beliefs and preconceptions to gain an awareness of their impact upon the process and study outcomes. In this way, I would increase the transparency (Brocki and Wearden, 2006). This reflection upon my own preconceptions is shown in Chapter four.

Husserl's (1913/1989) descriptive phenomenology has presented some interesting challenges for me. A contentious issue concerned the notion of bracketing. First, the process of bracketing would be both problematic and questionably attainable and second, if it were possible to perform, would render all my experience, thoughts and views in a suspended void, and my voice silent. Furthermore, Husserl's (1913/1989:39) approach involves the epistemological assumption that there are such things as 'universal truths', which are experienced in the same way by all individuals

with uniformity, as opposed to variability in human experience. Personally, I would conceive this as a form of objectivism, but despite claiming subjectivity, it seems far removed from a subjective approach. A study by Wall et al (2004) utilises Husserl's (1913/1989) phenomenological approach and describes the process of bracketing using a reflective diary, to make preconceptions visible, and subsequently suspend them from the investigation. Indeed, bracketing can be used as a method to safeguard researchers from data they may find emotionally challenging (Tufford and Newman, 2010) and can facilitate greater understanding of the phenomenon being researched (Rolls and Relf, 2006). However, Dreyfus (1987) adds that Husserl's (1913/1989) method of describing the lived experience of a person, views them as a detached subject existing in a world of objects. In contrast, Heidegger (1927/2010) believes that it is essential to understand the individual's *lifeworld* if one is to understand the individual. With this in mind I now turn my attention to Heideggerian phenomenology.

Heideggerian phenomenology (hermeneutics)

The term hermeneutics means 'interpretation' (Annells, 1996) and is derived from Hermes, the Greek god, who legend foretold was the interpreter between the gods and mortals (Thompson, 1990). Hermeneutics had previously been the term used in biblical translation in theological study (Gadamer, 1975/1996). Hermeneutic philosophy in Germany appears to have developed from the systematic hermeneutics of Fredrich Schleiermacher (1768–1834) in the early nineteenth century who studied the understanding of both the written text and personal communication. Wilhelm Dilthey (1833–1911) further developed hermeneutics, and received notoriety for his work in distinguishing the natural and human sciences. Dilthey was heavily influenced by the work of Kant and in particular his *Critique of pure reason*, wishing to develop it into a *Critique of historical reason*. Dilthey believed that the science of the mind could be divided into the structural levels of experience, expression and comprehension, and sought to establish an approach that could produce valid knowledge in disciplines such as sociology, anthropology and history (Draper, 1997).

Dilthey considered that 'understanding was essentially an interpretive process made possible by shared humanity' (Draper, 1997:68). Dilthey's work was to impact greatly on many subsequent philosophers, in particular Husserl (1913/1989) and Heidegger

(1927/2010). Modern hermeneutics was developed by Martin Heidegger, a student of Husserl (1913/1989). Heidegger rejects the epistemological focus of Husserl, in favour of an ontological focus (Annells, 1996). By discarding the subject-object relation, which was central to Husserl's approach, Heidegger (1927/2010) recognises that our consciousness does not necessarily exist in the way people relate to objects. Heidegger (1927/2010) believes that inquiry should not just describe core concepts, but should look for meaning, which may be embedded in life practice. Solomon (1987) articulates this to be what individuals experience as opposed to what they consciously know. Heidegger's (1927/2010) existential perspective holds that it is necessary to understand the person's *lifeworld* in order to understand the person. Heidegger (1927/2010) uses the term hermeneutics not to distance himself from Husserl (1913/1989) but instead to refer to his evolving work, which focuses on understanding as a mode of *being*, giving rise to knowing.

Martin Heidegger (1889–1976)

Martin Heidegger is arguably one of the most significant and influential philosophers of our time (Dreyfus and Wrathall, 2008). His seminal work *Being and Time* was published in 1927 and remains his most important and influential work. Heidegger (1927/2010) was a student of Edmund Husserl, and was heavily influenced by the work of Aristotle, and his beliefs around the realisation of presence being the essence of human existence. Heidegger (1927/2010) argues that Aristotle had misconceived the deep structure of 'taking as' and believed that the ancient Greek philosophers, in pondering 'the question of being' so deeply, had overlooked the actual question of the 'existence of being'. Plato believed that the ultimate reality was ideas Aristotle had turned to classification, while Socrates proclaimed we knew nothing. The theory of being had thus been split into dispersed entities of natural science, ethics, poetry and others. Heidegger (1927/2010) wishes to raise interest in the importance of looking at the very 'question of being', since being is the 'most universal concept' of all (Dreyfus, 1991:10C)

Heidegger (1927/2010) struggled to portray his theory using the existing language history had left at his disposal, and so makes the decision to create a new form of language, which was capable of conceptualising his thoughts and capturing the

nuances induced by the study and concept of 'being'. The words and philosophical language that Heidegger (1927/2010) introduced would also shroud his philosophy to outsiders and give his work an exclusivity of sorts. It is difficult then at times to readily understand his teachings, as even the translated German does not always fit with the equivalent English words. Language, however, is central to Heidegger's (1927/2010) analysis of the nature of *being*, and the words and punctuation that he creates are essential to his philosophy. I would use as an example of this Heidegger's (1927/2010) term *being-in-the-world*, which at first glance appears wrongly punctuated. The hyphens used, however, conjoin 'being' and 'in the world' together, as they are a whole, a unitary phenomenon. Heidegger (1927/2010) also asks us to examine the world, 'in the world-ness' and the being who is in the world in this instance.

Heideggerian concepts

Heidegger (1927/2010) returns to the basic question that is fundamental to all philosophy; the question of *being*. The nature of *being* is vitally important because the nature 'of being' implicitly subtends all other lines of scientific and intellectual enquiry. We must understand what it is *to be* before we can understand other things. Heidegger (1927/2010) answers the question by explaining what it is to be in the world, terming this *Dasein* or *being-in-the-world*. He describes *Dasein* as the fundamental unity of the subjective experience and the objective world. He explains that what we are and what the world is are mutually inter-dependent. There is no such thing as a world apart from our experience of it. He notes that human experience extends beyond knowledge of core concepts and essences into the concept of *Dasein*. It is important to note that *being* is not an entity, but every entity has a *being*. Heidegger (1927/2010:42) highlights that 'the Being of this being is always mine', essentially trying to understand ourselves. He also says that *Dasein's being* is its own 'possibility', meaning that it can make choices, whether to be itself or flee from itself; in other words to be authentic or inauthentic. The term *Dasein* is directly translated from the German word to mean '*being there*', meaning that the individual cannot abstract themselves from the contexts that influence their individual choices and give meanings to their own lived experience. Therefore, it is not the pure content of human subjectivity that is the focus of this study but, instead, it is about what the participant's description implies about their everyday experiences.

For this Heideggerian hermeneutic enquiry to identify if commonalities and differences exist between participants' own subjective experiences of their *lifeworld*, it is necessary to obtain detailed descriptions of their everyday experiences, interactions, work practices and socialisations (Smith, 1987). The existential focus for Heidegger (1927/2010) seeks to attain understanding of the phenomenon, and concludes that people cannot be fully understood if they are separated from their *lifeworld*. Bauman (1978:170) further notes that 'existence is its own disclosure'. It is also important to comment that the mode of existence is more fundamental than the manner of essence. Heidegger (1927/2010) demonstrates this when he says 'existential has priority over essential'. Furthermore, the average, everydayness of *Dasein* is the fundamental focus and must be investigated through this averageness. Campbell (2001) notes that Heidegger's (1927/2010) approach endeavours to take account of the cultural, social and political contexts that have a direct influence on individuals' life choices and behaviours. The value Heidegger (1927/2010) places upon exploring the average everydayness, which is influenced by our history and culture, makes his philosophy very applicable to this study. It was essential then that participants' experiences were not taken out of the context of their *lifeworld* and the impacting influences that are apparent. Heidegger (1927/2010) describes the process of uncovering what is concealed as *aletheia*, a word derived from Greek for 'the truth'. This process of discovery, from disclosure and interpretation, is likened by Heidegger (1927/2010) to shining a torch into the darkness, illuminating some things and leaving others in darkness.

Heidegger (1927/2010) rejects the notion of bracketing, instead taking the view that expert knowledge and preconceptions can be valuable assets to guide enquiry. He posits, that personal experiences and pre-judgements should not be suspended, but instead be used to assert an insightful influence upon the phenomena. Heidegger (1927/2010) believes that the process of understanding and interpretation is a reciprocal process, reliant upon the researcher's involvement and their ability to allow their interpretation to permeate through each stage of the research (Priest, 2004). McConnell-Henry et al (2009) observe that understanding is never without presuppositions, and concur with Heidegger (1927/2010) that these preconceptions can never be totally suspended. Koch (1996) adds that an interpreter always draws

on certain experiences and frames of reference during the process of understanding and these cannot be bracketed. This concept by Heidegger (1927/2010) very much reflects my own feelings, whereby my insight, experience and preconceptions can play a valuable part in the research study.

Heidegger (1927/2010) advocates a process of disclosure of preconceptions relating to the phenomenon in question, using the term 'fore-structures of understanding'. To clarify, *fore-structures* of understanding are based on the supposition that *Dasein* and *situatedness* create a situation of preunderstanding. This is explained by the fact that every individual brings their own socio-cultural and socio-economic background practices from their own worlds. Indeed, prior to the commencement of the interviews it was important that I made my preconceptions or *fore-structures* visible. In bringing these previously held views to the fore of my consciousness, I was made aware of them and the ways in which they may influence or fuse with the participants' own ideas and experiences. Heidegger (1927/2010) makes the assumption that *fore-structure* is directly linked with the individual's view and understanding of the world, and how reality is interpreted. Heidegger (1927/2010) describes these *fore-structures* as *fore-having* (background practices), *fore-sight* (socio-economic background) and *fore-conception* (socio-cultural background).

It is, however, *understanding* that enables *Dasein* to exist, as we become aware of our own existence. It is crucial there is understanding, as without an understanding of *Dasein*, there can be no *Dasein*. Heidegger (1927/2010) teaches us that the *priori* understanding of *Dasein* is our own *Dasein*, our own being, saying:

Understanding is the existential Being of *Dasein*'s own potentiality-for-Being; and it is so in such a way that this Being discloses in itself what its being is capable of. (Heidegger 1927/2010:144)

In *Dasein* we are always in the world with *care* never in the world indifferently. In this context, *care* is described more in terms of emotion, in terms of concern, such as animosity or hatred. *Care* is a *structure of our being* and is communicated in the many ways in which we relate to things. Heidegger (1927/2010) describes the way we relate to other people in terms of *concern* and *solicitude*, in our *being-with* and *being-in-the-*

world. These ways of interacting with others is used to look at the ways in which participants relate to colleagues and patients in their *being-in-the-world*. *Solicitude* is a state of *Dasein*'s being. Heidegger (1927/2010:122) describes *solicitude* as having two distinctions: *leaps-in* and *leaps-ahead*. In the first mode of *solicitude*, the individual 'leaps in and takes over' and in doing so takes care away from the other person. Taking the characteristic of *leaping-ahead*, this action serves not to take care away, but instead seeks to empower, in effect giving care back authentically (Heidegger, 1927/2010:122). These two modes of behaviour are relatively self-explanatory and can be applied to nursing with ease. Both behaviours have a useful place in different situations. *Leaping-in* would be useful in times of danger or when people are unwell or debilitated, and *leaping-ahead* could be seen as a means of empowering and facilitating health outcomes. However, I also use these modes of behaviour to describe how they could be useful in managerial behaviour, through degrees of practical assistance and empowering. Heidegger (1927/2010) uses the terms *care* and *solicitude* to discuss how *being-with* is expressed through *being-in-the-world*.

Heidegger's (1927/2010) philosophy teaches us a basic lesson, that *being is time*. We exist *temporally* between birth and death. Time is limited and ends when we die. It is, therefore, essential according to Heidegger (1927/2010) if we are to achieve *authenticity* that we constantly think about the inevitability of our death and find meaning in our limited time of being. He calls this way of being *being-towards-death*. Time defines all human existence, giving us a past, a personal and cultural history, a present and finally a future, represented by *possibilities*, which are there to choose or not to choose. Heidegger (1927/2010) refers to this as *ways to be*. Heidegger (1927/2010) asserts that our past, present and future are closely associated to each other in a dynamic way, with each dimension being strongly influenced by the others. He refers to *temporality* as the term used to describe time as the horizon for the understanding of *being*, since *temporality* is the concept that unites our past, present and future, and in doing so affects the way in which reality is generated. Heidegger's (1927/2010) own words perhaps best describe this concept:

Time must be brought to light and genuinely grasped as the horizon of every understanding and interpretation of being. For this to become clear we need an original explication of time as the horizon of the understanding of being, in terms

of temporality as the being of Dasein which understands being. This task as a whole requires that the concept of time thus gained be distinguished from the common understanding of it. (Heidegger, 1927/2010: 18)

As a researcher, Heidegger's (1927/2010) concept of *temporality* is an important point. It conceives that the experiences we hold from the past, and our experiences about our own *lifeworld*, can bring us to new understandings and allow us new possibilities. Heidegger (1927/2010) uses the concept of *having-been-ness* (*Gewesenheit*) to describe the personal and cultural influences brought with us from the past, not as 'baggage' to hold us back but as opportunities to allow us to make informed decisions about our future, a situation he called *resoluteness*. The present is then opened up into possibilities for *Dasein*, of *potentiality to be*, the '*moment of vision*' (*Augenblick*). So, time is conceived, not only in the conventional manner, but as a projection into the future, which is not restricted to the present and not held back by the past (Heidegger, 1927/2010). In valuing the individual's experience of their *lifeworld*, alongside the researcher's own temporality, this approach offers a synergy to nursing, which I endeavour to explore in the next section.

Phenomenology and nursing

Phenomenology is commonly used in nursing research as the approach allows an in-depth understanding of human feelings and wholeness (Wojnar and Swanson, 2007). This methodology is akin to the holistic approach used in nursing as it values the individual's experience and beliefs (Reiners, 2012). Heidegger (1927/2010) believes that individuals are capable of finding significance and meaning within their own lives and further asserts that the understanding of individuals cannot occur in isolation of their own culture, history and social context (Burke-Draucker, 1999; Campbell, 2001). Swanson and Wojnar, (2004) describe the heart of phenomenology as its ability to apply description and understanding to phenomena such as caring and healing as experienced by individuals. Meleis (1996) asserts that phenomenology provides knowledge to the nurse researcher, which is relevant and respectful of the social and cultural realities that exist for the individual. It offers an approach to inquiry that compliments the philosophy and the art of nursing: aiming to understand the

uniqueness of individuals, their meanings and their interactions with others and the environment (Lopez and Willis, 2004).

Hermeneutic phenomenology posits that the researcher should reflect on their own experiences of caring and being cared for and explore their own preconceptions about healing and holism. This will allow the researcher to access the *fore-structure* of understanding during the interpretive process. In adopting a hermeneutical approach, the researcher must focus on describing the meanings of the individual's *being-in-the-world* and look at how this influences the choices they make. Smith (1987) comments that the researcher may need to look at the social and political drivers that influence their decision choices in the context of their life events. Heideggerian hermeneutics focuses on the average everydayness of the individual's being, and the meaning of its everyday *being-in-the-world*. It acknowledges the fragility of life and the inevitability of death, in much the same way as the philosophy of nursing does. With these points in mind, it is pertinent to look at the work of other authors and scholars who have used a phenomenological based approach to gain an understanding of phenomena present in nursing.

Phenomenological based studies in nursing

To begin with it is relevant to acknowledge there has been ongoing criticism levied at many nurse researchers that phenomenology and hermeneutics have been incorrectly used and understood. Crotty (1996) and Paley (1997) spearheaded these criticisms, observing that the focus on experience by nurses was problematic and did not reflect the ethos of phenomenology, and research was often lacking the methodological underpinnings required. Crotty (1996) in his paper 'phenomenology and nursing research' carried out a review of 30 randomly selected phenomenological studies completed by nurse researchers, and contested that they were not phenomenological, in keeping with the European tradition, being less descriptive and more subjective.

Paley (1997, 1998) asserts that nurse researchers have frequently misinterpreted and failed to understand the philosophical work of both Heidegger (1927/2010) and Husserl (1913/1989). Paley (1998:820) attributes such researchers' misinterpretation of hermeneutics to 'reading Heidegger through other authors', and thereby taking on

another's interpretation. However, Giorgi (2000) refutes the criticisms of Paley and Crotty, observing that both use a universal philosophical criterion instead of making a distinction between scientific and philosophical phenomenology to define fault with scientific process. Giorgi (2000) fears that this onslaught of condemnation could lead to a decline in nurses using phenomenological research. Although Giorgi (2000) acknowledges there are some examples of poor application, he encourages researchers to continue with the tradition, doing it better by gaining a deeper understanding of the philosophy. The main problem I have noted when reading some of these studies is that often no differentiation is made between phenomenology and hermeneutics, and they are often referred to as being one and the same research approach. Stubblefield and Murray (2002) contest that applying a methodology that lacks philosophical foundation can have implications on findings.

In reviewing phenomenological studies in nursing, I encountered a number of studies utilising Giorgi (1989) and Colaizzi (1978) whose approaches are largely based upon Husserl's (1913/1989) descriptive phenomenological philosophy. The 'descriptive phenomenological psychological method' of research developed by Giorgi (2005) advocates a structured methodology using the following steps: (1) phenomenological reduction; (2) description; and (3) search for essences. Colaizzi (1978) developed a methodology underpinned by elements of hermeneutics and phenomenology and observed a descriptive approach to obtain the meaning of an experience from the individual's perception. A nurse researcher who has utilised Colaizzi's methodology is Phipps (1993) who investigated the lived experience of infertility for infertile couples. Colaizzi (1978) advocates the utilisation of this methodology in a flexible way, and omits elements of Heidegger's (1927/2010) philosophy such as co-constitutionality and researcher interpretation. Colaizzi (1978) does not place significance upon the researcher's own preconceptions, which according to Heidegger (1927/2010) can increase our understanding.

Nurse researchers Ajjawi and Higgs (2007) demonstrate the use of van Manen's (1984) methodology in their study to investigate how experienced practitioners learn to communicate clinical reasoning. Van Manen (1984) developed a methodology to study the nature of lived experience, existential investigation and phenomenological writing, which he refers to as the 'phenomenology of practice'. Van Manen's (1984)

work is guided by Gadamer's (1975/1996) 'philosophical hermeneutics', to discover the nature of human understanding. His philosophical beliefs build upon the work of hermeneutics. Gadamer (1975/1996) believes that all individuals are affected by our history, and their historical consciousness has shaped us and continues to affect us in our lives and our understanding. Indeed, he posits that understanding is not possible without historical awareness. Like Heidegger (1927/2010), Gadamer (1975/1996) sees our preconceptions as a positive and integral part of our interpretive process and warns that failing to identify one's preconceptions may result in misunderstandings. Van Manen (1984) suggests that the researcher should acknowledge their preconceptions, experience and knowledge, and identify how these views may influence the data collection, analysis and interpretation. The hermeneutic circle is utilised to move between parts of the text and the whole, combined with the researcher's understanding of each individual part, with reference to the whole. This use of hermeneutics describes how the researcher interprets the 'texts' of the participants' lived experience and discovers the meanings in language. Van Manen's (1984) work has offered many interesting thoughts and influenced the way that I arranged the essential concepts into headings, when analysing the data.

In the field of psychology, Smith and Osborn (2003) developed Interpretative Phenomenological Analysis (IPA), which adopts an idiographic and inductive method and aims to offer insights into participants' personal lived experiences. IPA recognises the importance of the role of the researcher and identifies with the work of Heidegger (1927/2010) and the hermeneutic tradition but also acknowledges Husserl's work on phenomenological reduction, resulting in an approach that is descriptive and interpretive. IPA fuses ideas from phenomenology and hermeneutics culminating in a situation whereby the researcher creates a 'double hermeneutic' by constantly moving the focus from participant to researcher and back again, using inquiry and 'meaning making'. IPA presents an interesting synthesis of phenomenology and hermeneutics and makes the philosophical underpinnings clear.

Benner (1984) developed a methodology underpinned by the philosophy of Heidegger (1927/2010) and Gadamer (1975/1996) using a three-stage interpretive process of thematic analysis, analysis of exemplars and identifying paradigm cases. Benner (1984) uses specific exemplars gained from interview transcripts to depict the

differences and nuances within and between the emerging themes to demonstrate identified patterns and meanings from paradigm cases. Benner (1984) uses Heidegger's (1927/2010) hermeneutic circle in her approach, advocating that the researcher moves between the parts and the wholes of paradigm cases and exemplars, which she conceptualises as cycles of understanding, interpretation and critique (Benner, 1994:116). Her study "*From novice to expert*" attempts to study the individual in their current situation rather than separating them from all the variables that surround them. Benner (1984) interviewed 21 pairs of nurses, with one of the pairs being a newly qualified nurse and the other, their preceptor, an experienced nurse. She then utilised a five-stage tool, that being the Dreyfus model of skill acquisitions (Dreyfus and Dreyfus, 1985), to describe the potential development of nursing expertise. Benner's study had a profound effect upon nurse education and training and encouraged nurse researchers to study and utilise a hermeneutic approach. Benner's (1984) work has been met by critics, who have disputed the methodology as being underpinned by Heidegger's (1927/2010) philosophy (Koch, 1995; Crotty, 1996; Padgett, 2000). A pertinent point I would make is that Benner's (1984) perspective on ontology differs from Heidegger's (1927/2010). Heidegger (1927/2010) viewed ontology as essential to understanding *Dasein*, which poses the question 'What does it mean to be a person?' In contrast, Benner seeks an epistemological perspective, asking 'How do we know what we know?' Benner demonstrates the value of the researcher's background to the interpreter's role, along with a respect for the participant's knowledge to the nursing profession.

A nursing study carried out by Barnett (2005) to gain an understanding of the experience of living with chronic obstructive pulmonary disease utilised Diekelmann et al's (1989) seven-stage process of phenomenological analysis. The methodology developed by Diekelmann et al (1989) has been referred to as objective hermeneutics because it seeks to gain validation by a third party to determine that the interpretation is objective and true (Thompson, 1990). Diekelmann et al (1989) used the hermeneutic approach to transform the nursing curriculum in America. The seven-stage process seeks to remove any inconsistencies by observing several levels of interpretation and analysis, applying the theory of the hermeneutic circle. Although it is difficult not to be impressed with Diekelmann et al's (1989) study impact and influence, the research

process and use of third-party involvement to establish truth does lead me to conclude this analytical approach seems rather inductive and objective in nature.

Parse's (2001) study, later developed by Ortiz (2009), utilises the 'human becoming hermeneutic' method in their nursing research, following in the Heideggerian-Gadamerian tradition. Using Heidegger's (1927/2010) ontological perspective, Parse (2001) highlights the basic assumptions underpinning this methodology. This method seeks to discover the meanings of human experience by engaging in discourse with the text, art form and author. It is acknowledged that all researchers will engage in discourse, interpretation and understanding differently and uniquely (Ortiz, 2009). This methodology has been successfully used by nurse researchers, such as Bunkers (2012) who studied the lived experience of feeling disappointed from the perspective of patients within a healthcare setting in America. The study demonstrates how the use of Parse's methodology attempts to uncover the universal lived experiences of health by studying the dialogue used by participants, then using 'extraction-synthesis, and heuristic interpretation' of the data (Parse, 2001:189). Although this research offers a unique approach, which is centred on nursing, its methods seem incongruent to Heidegger's (1927/2010) thoughts on *Dasein*, and the concept of unique personal experiences. The 'human becoming theory' (Parse, 2001) operates a 'closed circle' approach, which in some ways contradicts the ethos of the hermeneutic circle. The work by Parse (2001) and Ortiz (2009) also chooses not to engage with Heidegger's (1927/2010) thoughts on *authenticity*.

A leading nurse scholar, Koch (1996), adopted a Gadamerian philosophy along with the framework of Guba and Lincoln's (1989) fourth generation evaluation in order to investigate the experiences of elderly patients who have been admitted to hospital. Koch (1995) sought to 'hear' the voices of the participants involved in the study. The study interviewed 14 patients admitted to a care of the elderly ward, and used contextual data portraying the lived experience of the patients involved. Koch (1996) makes a clear argument for her methodological decision and its implications upon the study. Koch's (1996) study is underpinned by the assumption that an evaluation can fail to hear all parties' concerns, and so she starts with the patient's voice, and seeks to find their experiences of being in hospital on an acute unit. The study uses Gadamer's (1975/1996) concepts of the hermeneutic circle, preunderstanding and

openness. Koch's (1996) use of reflexivity and co-constitutionality made her work extremely poignant, as she articulates her personal thoughts and experiences. Koch's (1996) openness allows the reader to clearly visualise her decision trail, adding credibility to the study.

In summary, this chapter has discussed the philosophical ideas that underpin this study and will later be used in collecting and analysing the data. Heidegger's (1927/2010) philosophy has had a profound effect upon me, although the learning process has been extremely problematic. Getting to grips with the elaborate prose, which Heidegger (1927/2010) so expertly uses, was initially very confusing and frustrating, made worse I think by the fact that many of the words do not accurately translate into English. Eventually things started to make sense and I found clarity in his work, which brought with it a fascination in his theories. By presenting a clear understanding of Heidegger's (1927/2010) philosophy and its phenomenological roots, I have justified my reasoning for selecting this work to underpin this study. Indeed, the reading of other nurse scholars has allowed me to formulate a methodology, which I explain in the next chapter (Chapter, 4). Certainly, in viewing how others have or have not underpinned their work in philosophical theory has been extremely influential in searching for the right approach to use. The work employed by other researchers underpinned by a phenomenological based approach illustrates the natural synergy that exists between this philosophy and nursing. This is seen in the importance attached to individuals' holism and the value of their unique experiences within the contexts of their lives. It is hoped that this study will generate new perspectives, disclosed through a hermeneutical lens, which may lead to a different understanding of the nurse's *lifeworld* in respect to how they experience professional accountability. The next chapter articulates how I selected a methodology in order to proceed with the research process.

Chapter Four: Methodology

Overview

This chapter outlines my search for a methodology with which to obtain rich experiential data, in keeping with the aims of this study. It describes the hermeneutic circle, and the reflexive approach I endeavoured to pursue. This chapter then gives a personal account of my perceptions about nursing, before presenting my own preunderstandings of the phenomenon being studied. In doing so, I detail the importance and purpose of the reflective process in bringing my own *fore-structures* into my awareness. In this way, I hope to demonstrate a transparency in my interpretations and an openness and integrity to the research process. I stress that the reflective process is an ongoing process and occurred throughout the study. The chapter closes by examining how this study maintained quality through rigour.

Introduction

Having defined and described the philosophy of phenomenology and of hermeneutics, I found myself floundering somewhat to find a methodology and research design that would be the best 'fit' with my aims and hermeneutical underpinnings. Indeed, there are many variations in the application of phenomenology and many variations in the application of the methodologies used, depending upon the type of phenomenology being used and the researcher's aim (Finlay, 2012). Phenomenology, according to van Manen (2014:29), represents a 'philosophical method of questioning not a method of answering', making each study unique as there are no blueprints for practice. Indeed, Merleau-Ponty (1962/2006) asserts that an understanding of phenomenology only really comes from doing the research. The process of actually doing the research means that it is a lived experience for the researcher, as they align themselves to the ontological nature of the phenomenon being studied (van Manen, 1990). Smythe et al (2008:1389) describe the practice of undertaking this type of research as a 'journey of thinking' involving the ongoing cyclical process of 'reading, writing and dialogue'. Furthermore, Heidegger (1927/2010) observes that in this way the researcher begins to see the essential understandings and taken for granted everydayness through the lens of their preconceptions. Heidegger (1927/2010) is clear, however, that the ethos

of hermeneutics is concerned with looking for the unique meanings, modalities and variations in the participants' stories and thinking, and understanding is embedded in our *being-in-the-world*.

The process of illumination in phenomenological research is likened to a prism, where one part is at times hidden whilst another part is disclosed (Kafle, 2011). Furthermore, van Manen (1984:36) advocates that researchers should study the various techniques employed across phenomenology and hermeneutics, stating, 'it makes us thoughtfully aware of the consequential in the inconsequential, the significant in the taken-for-granted'. Adding that by focusing upon illuminating the detail that is often taken for granted, we can create a sense of understanding. Lawler (1998) observes that the lack of direction regarding data analysis means that nurses sometimes have to formulate their own research design in order to manage phenomenological research. Likewise, Finlay (2012) notes that a phenomenological approach can adopt a unique stance since this field of study is complex and ever evolving. Garza (2007) concurs with this, observing that phenomenology as a research method is both flexible and adaptable.

Selecting a methodology

In selecting a research methodology, it was important to me that the study reflected the general guidelines for hermeneutic research, which are that the research demonstrates a 'dynamic interplay' between research activities. These are observed by van Manen (1984:39) as;

- A commitment to an abiding concern,
- An oriented stance toward the question,
- An investigation of the experience as it is lived,
- A description of the phenomenon through writing and rewriting,
- A consideration of parts and whole.

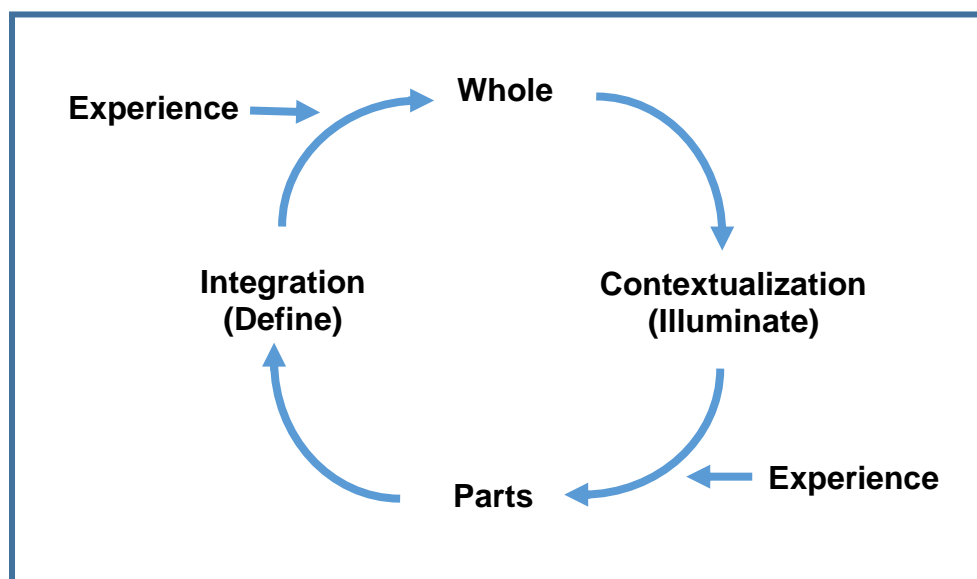
The methodology I followed adopts van Manen's (1984) research process detailed above and incorporates the notion of the *lifeworld*. The *lifeworld* of the individual or human experience as it is lived demonstrates the fundamental goal of hermeneutic phenomenology (Wilson and Hutchinson, 1991). Heidegger (1927/2010) holds that

understanding is gained not through knowing, but through relationships, by describing an interpretation of *Dasein*. I utilised the idea of the *lifeworld*, not as a pre-reflective state, as depicted by Husserl (1936/1970), whereby universal truths are uncovered through suspending our pre-suppositions, as the truth is not grounded in time or culture (Walsh, 1996). Instead I conceptualised the *lifeworld* from a hermeneutical perspective, describing individuals' *being-in-the-world*, inseparable by our very existence from the world and its influences (Heidegger (1927/2010). In other words, *Dasein* is our *being-in-the-world*, situated in time and culture, which as we are *thrown* into the world equips us with a *primordial kind of knowing* which precedes consciousness in Husserlian terms (Walsh, 1996: 233). Gadamer (1975/1996:247) furthers this idea, describing the lifeworld as '*the whole in which we live as historical creatures*'. By adopting van Manen's (1984) research process and the concept of the *lifeworld* I was able to explore the perceptions and insights of the nurse's *lifeworld* in terms of their own professional accountability. In doing so, I hoped to gain valuable insights into what factors influence participant's everyday nursing practice, and indeed their personal accountability, and how these factors impact upon patient care in real terms.

In staying close to Heidegger's (1927/2010) philosophy, the fundamental tool used to interpret the data was the 'hermeneutic circle'. The hermeneutic circle is a concept originally devised by Schleiermacher (1768–1834) who recognised that 'understanding is a circular phenomenon in which a simultaneous comprehension of the whole and the parts is required' (Draper, 1997:66). Heidegger (1927/2010) notes that Schleiermacher's hermeneutics was influenced by the Cartesian tradition, and failed to acknowledge the value of the interpreter, as it considered their experiences and views to represent a potential source of bias. In contrast, Heidegger (1927/2010) believes that the interpreter's understanding of what is to be interpreted is essential and uses the hermeneutic circle to conceptualise his vision of wholeness positioned in the individual's *lifeworld*. It refers to the idea that in order to come to an understanding of the whole text, we must understand the individual parts and then refer back to the whole text. The meaning of the text must be viewed with the culture, history, and literary and political contexts. Its form is circular as it has no end, with interpretation requiring the whole and the parts, with the process moving between parts and whole and back again. This concept of the hermeneutic circle is likened by

Heidegger (1927/2010) to the understanding apparent in understanding art. He makes the point that both artists and their art work can only be understood in relation to each other. Figure 1 shows a diagrammatical portrayal of the hermeneutic circle (Reproduced from Bontekoe, 1996).

Figure 1: Hermeneutic circle (reproduced from Bontekoe, 1996)



Heidegger's (1927/2010) hermeneutic circle with the *fore-structure* of *Dasein* is described as:

This circle of understanding is not an orbit in which any random kind of knowledge may move; it is the expression of the existential fore-structure of *Dasein* itself. The circle is the result of the structure of meaning which rises from the nature of all interpretation structure of meanings, and the latter phenomenon is rooted in the existential constitution of *Dasein* – that is, the understanding which interprets. (Heidegger, 1927/1962:195)

The concept of the hermeneutic circle is one of holism, capturing the parts that make the whole and the whole in relation to its parts. Nurse researchers have widely utilised the hermeneutic circle as a method of data analysis, to gain a deeper understanding

of individuals' experiences relating to a phenomenon. In a hermeneutic study by Jack and Wibberley (2014) the hermeneutic circle was used to explore the emotional nature of nursing with student nurses. Another hermeneutic study by Robstad et al (2017) demonstrates how the hermeneutic circle allowed the researchers to uncover new insights pertaining to nurses caring for obese patients in intensive care settings. However, the application of the hermeneutic circle in research is not confined to phenomenological studies and is frequently used in other qualitative studies to explore participant text. A research study by Tetley et al (2009) adopted a constructivist approach exploring the decision-making practices of older persons in health and social care settings and used the hermeneutic circle to enrich the data and present a different understanding of how the decision processes of individuals were influenced. Koch and Harrington (1998) assert that in utilising the hermeneutic circle, researchers adopt a reflexive approach, requiring an awareness of their own background understanding and the influence they may apply to the data, made visible in keeping a reflective journal throughout the research process.

The theory of understanding notes that understanding is deepened through the discourse and reflexivity of our preconceptions (Gadamer, 1975/1996). Indeed, the methodology must be responsive to the phenomenon and the subjective mutual connection between the researcher and the researched. Therefore, the fundamental process of reflexivity must represent an integral component of this research approach. Reflexivity involves the researcher reflecting continuously upon how their own values, actions and preconceptions alongside those of their respondents, impact upon the research setting, the interview and analysis process (Gerrish and Lacey, 2006). Furthermore, reflexivity captures the idea of researchers being open and honest, exposing a vulnerability to the reader, as does the research participant by sharing their innermost thoughts and feelings. Morrow (2006) concurs with this, seeing reflexivity as an approach that researchers can use to gain a greater understanding of the phenomenon and expose the meanings made by participants, whilst allowing the researcher's thoughts and feelings to be understood. Enosh and Ben-Ari (2016) describe reflexivity as the notion of continuous movement regarding being in the phenomenon and moving outside it and suggest there are three applications of reflexivity: the researcher, the participant and the encounter. Willig (2001) asserts that by the researcher gaining an understanding of the reflexive process, they are

motivated to reflect upon the assumptions and expectations they have acquired whilst being engaged in the research study. The reflexivity of the researcher can be thought of as two processes, one of discovery and one of construction. By recognising incongruities, discrepancies and contradictions, the researcher finds new knowledge and can use this to challenge existing knowledge and beliefs (Enosh and Ben-Ari, 2016). Indeed, Alvesson and Sköldberg (2000: vii) observe the nature of reflexivity as:

Interpreting one's own interpretations, looking at one's own perspectives from other perspectives, and turning a self-critical eye onto one's own authority as interpreter and author. (Alvesson and Sköldberg, 2000: vii)

During the process of unpacking the meaning and process of reflexivity, I came across the writings of Savin-Baden (2004) that helped me make sense of how I as a researcher would position myself. She explained this is a complex process, due to our own changing perspectives and the way in which we interpret the collected data and make sense of people and their contexts. She advises researchers avoid coding and lists, instead becoming absorbed within the pain of self-critiquing, which is required to interpret the data. She suggests some of the positions she has taken in her own research are that of a researcher, a co-inquirer and a confidante and sympathiser.

To situate ourselves in relation to the data we need to ask ourselves, and our participants, questions that not only rest on a desire to understand people's experiences of the issues under study, but also explore the ways in which these experiences do and do not relate to the broader context of past, present and future selves. (Savin-Baden, 2004:368)

Denzin (1989) describes the moment when the analysis changes to the interpretation as an 'interactional' moment, or an 'epiphany'. He describes four forms of epiphany, when challenges produce changes to one's perspective. Denzin (1989) observes that all these epiphanies are transformational because they mark a change to the individual's life. By using the concepts of reflexivity and the hermeneutic circle, I demonstrate honesty, integrity and openness, exploring my own feelings, and sharing my own experiences, alongside those of the participants. It is the fusion of these horizons that allow new meanings to be uncovered (Gadamer, 1975/1996). The

approach undertaken complements the philosophy and art of nursing, by understanding the uniqueness of individuals and their interactions with others and their environment. Of course, by adding my own voice to the research there becomes a danger the study becomes narcissistic in nature, and my own experiences overwhelm those of the participants. Koch and Harrington (1989) suggest the best defence to overcome any risk of narcissism is to ensure there are many audible voices and their influences are present in the study text. Gullion (2016) concurs with this view advising researchers to weave their own experiences within the text, whilst making visible their own perceptions and how these views may have influenced or been changed by the research process. In keeping with a hermeneutical approach, a co-constitution of the data is made, so that my own experiences and feelings sit alongside those of the participants and the philosophy of Heidegger (1927/2010).

This study seeks to emulate Heidegger's (1927/2010) approach as an ontologist, striving to uncover the meaning of *being*, in this case elucidating the humanistic meaning of the experience of nurses' professional accountability. Heidegger (1927/2010) acknowledges the need for the researcher to have prior knowledge of the phenomena, which allows us to access the participant's *lifeworld* and interpret their experiences. These prior experiences are identified as preconceptions or *fore-structures* which are already present in the researcher's mind. Heidegger (1927/2010) also places importance on the temporal distance on our understanding, as both researcher and participant are influenced by their past and present. By evaluating my own preconceptions, this increased my awareness of any effects these may have upon the research process. A deeper understanding of the phenomenon was thereby facilitated allowing for a transcendence of horizons, whereby the researcher's experiences are fused with the participants' (Geanellos, 1998).

Personal reflections and methodological approach

As a researcher I have chosen the phenomenon of professional accountability as it is connected to my own biography. My nursing career began in 1986, and as I reflect on those times, I see nursing then as something quite far removed from nursing today, and set in a very different landscape. I recall the mantra often recited that the NHS was a 'no-blame culture'. I have never managed to view the culture of the NHS as 'no

blame', and I have always felt the unwritten and unspoken fear of recrimination if one was ever to speak out against injustice or wrong-doing. This notion of not being able to raise concerns was established when I was a second-year student nurse, an event which I was reminded of whilst undertaking the interviews. It is many years since I thought about this and the memory still brought back feelings of anger within me. The following account is from my reflective diary:

During my nurse training, in the eight week theatre placement, I was allocated to work in anaesthetics. On one particular day, i witnessed a senior anaesthetist make derogatory comments about a patient's appearance whilst they were naked and unconscious on the operating table. I reported the incident to my school of nursing tutor. My disclosure was met with both sympathy and empathy and with the benefit of hindsight, probably common sense. She kindly thanked me for bringing it to her attention and assured me that reporting this sort of behaviour was entirely right, but that if I made an official complaint the anaesthetist in question would be told my identity and the placement may be difficult for me. She also reminded me that at the end of my training I would need to apply for a job, and that it was always better to have a 'clean sheet'. I perceived that she felt apprehensive and was frightened by my desire to make a complaint. In the historical context of the day, nurses did not stand up to doctors and would never have criticised their practice. Indeed, when I spoke about this experience at the time with my peers, my experience was not an isolated one and others had witnessed incidents not dissimilar to mine. Indeed, as students we were often shouted at and admonished in public displays of anger by medical staff and senior nurses. As students, we would give evaluations of our placements to our tutors who were aware of the 'infamous' ward sisters and how difficult some placements would be, yet seemed powerless to intervene or change things. As student nurses, we were told frequently that the training system would face a radical overhaul when project 2000 was launched, which made me feel that our collective concerns were generally overlooked.

I would describe my nurse training in the late 80's as 'character building', which was probably the intended brief. Although I look back on this time in my youth as

pleasurable, the nurse training was a very flawed process, and bound up with anxiety. Anxiety was a shared emotion with my peers throughout my training, and it was viewed as normal to be anxious about a placement or person. The style of nursing during my early career was task orientated, and the concept of nursing becoming 'patient centred' was greeted with much cynicism and negativity from senior staff. I can recall the great excitement as a staff nurse embarking on 'primary nursing', which allowed, for perhaps the first time, the opportunity of building relationships with our patients and affording us continuity of care. This occurred at the time when 'degree nurses' were first introduced, and I can remember being told by an experienced registered nurse that they would be no good at 'proper hands on nursing, as they were purely classroom taught'. I also remember thinking how lucky they were to have come out with a degree. This desire for academic achievement was to remain my focus for the next 30 years, achieving a BSc (Hons) in nursing practice through the completion of various modules, attained over a five-year period, before gaining post graduate qualifications, and then a Master's degree. My focus throughout this education process has been in seeing advancement in the practice and profession of nursing. Heidegger (1927/2010) observes that our own history creates our preconceptions, and therefore it is through these experiences that I have developed these *fore-structures*, detailed in the next section.

Reflecting upon *fore-structures* and preunderstandings

The hermeneutic circle is a metaphor to describe the dialectical movement between the parts and the whole, and back again, in a circular motion (Koch, 1996). This process of interpretation involves the researcher entering the circle and moving constantly between interpreting parts of the text and interpreting the whole text, with the researcher gaining understanding before reinterpreting and continuing until an understanding is reached through the whole and the parts. The approach acknowledges the importance of the interpreter's understanding of what is to be interpreted and utilises this to develop a vision of wholeness situated in the individual's *lifeworld* (Dahlberg et al, 2008). Bontekoe (1996) suggests that the hermeneutic process comprises an examination of the composite parts, before reintegrating them back to the whole. This concept of holism is fundamental to the interpretive approach. Heidegger (1927/2010) asserts it is essential that the hermeneutic circle is entered in

the correct way, which means that the researcher should have brought their *fore-structures* and preunderstandings into their consciousness. The rationale for this is that without such reflection there is a real danger the research will uncover what the researcher already knows, rather than shedding new light upon the phenomenon. In the following passage, taken from *Being and Time*, Heidegger (1927/2010) conceptualises this theory:

The circle must not be degraded to a vitiosum [vicious] not even a tolerated one. A positive possibility of the most primordial knowing is hidden in it which, however, is only grasped in a genuine way when interpretation has understood that its first, constant and last task is not to let fore-having, fore-sight and fore-conception be given to it by chance ideas and popular conceptions, but to secure the scientific theme by developing these in terms of the things themselves. (Heidegger, 1927/2010:153)

In the above quotation, Heidegger (1927/2010) advises that the hermeneutic circle, is not to be viewed as a vicious circle, but as a vehicle to promote understanding through interpretation. Heidegger (1927/2010) acknowledges that our preunderstandings cannot be separated from oneself, indeed he rejected the idea of bracketing, but believed that the researcher's preconceptions should be acknowledged, and valued. Gadamer (1975/1996) also underlines the need for researchers to acknowledge their preunderstandings and recognise their background history, tradition, culture and language, arguing the idea that situated interpretive activity is a central tenet in the pursuit of understanding. Therefore, my preunderstandings or *fore-structures* should be brought to the fore of my consciousness, in readiness for entry into the hermeneutic circle.

For both Heidegger (1927/2010) and later Gadamer (1975/1996), the term *fore-structure* is a central concept. It has been argued, however, that the interpretations of the two scholars differ slightly (Geanellos, 1998). Heidegger (1927/2010) develops the theory of *fore-structures* of understanding. By this he means all individuals are impacted by their background, environment and culture. He split the *fore-structure* up into three sections: fore-having (background practices); fore-sight (socio-economic background); and fore-conception (socio-cultural background). Heidegger

(1927/2010) posits that these *fore-structures* are intrinsically linked with a person's view and understanding of the world, and determine how they interpret reality. Heidegger (1927/2010) also observes that our *fore-structures*, which make up our preunderstandings, are essential to the interpretive process, allowing insight into the phenomena. Gadamer (1975/1996) adds to Heidegger's (1927/2010) theory of *fore-structure*, using the term 'vorurteil', which roughly translates as pre-judgement, and when in the context of his writings, appears to mean preunderstandings. He defines preunderstanding as referring to our provisional judgments and also to mean prejudice, using the modern recognition of the term. Gadamer (1977/2004) acknowledges the negative connotations of the word prejudice, and makes a conscious decision to use it in a positive light, in an attempt to rehabilitate the word. The following extract by Gadamer (1977/2004) articulates this point:

Prejudices are not necessarily unjustified and erroneous, so that they inevitably distort the truth. In fact, the historicity of our existence entails that prejudices, in the literal sense of the word [prejudgment], constitute the initial directedness of our whole ability to experience. Prejudices are our biases of our openness to the world. They are simply the conditions whereby we experience something – whereby what we encounter says something to us. This formulation certainly does not mean that we are enclosed within a wall of prejudices and only let through the narrow portals those things that can produce a pass saying, "Nothing new will be said here". (Gadamer, 1977/2004:9)

In the practical act of bringing my *fore-structures* and preunderstandings relating to the phenomenon into my consciousness, I found the writings of Gaenellos (1998) incredibly useful. In her hermeneutic study into the care of adolescents in a mental healthcare setting, she shares the way in which she deals with this reflective process, by making 20 statements detailing her beliefs about the phenomenon, and then going on to interpret and find meanings in her own words and thoughts. At the outset of this research study I began to keep a reflective journal, detailing my thoughts and feelings throughout the process. Following Gaenellos' (1998) approach, to make visible my thoughts and perceptions about professional accountability I drew up five statements, which I briefly interpreted and analysed.

Revisiting the aims and objectives of this study

A reflection upon the aims of this study is useful here, to allow a recap for the reader. My existing preconceptions have of course influenced these aims, and this will become apparent as my preconceptions are made clear. The aims of this study are as follows:

- To explore the perceptions and insights of nurses' experience in terms of their own professional accountability whilst working in the NHS.
- To explore factors that influence nursing practice and individual accountability.
- To explore the impacts of nurses' professional accountability on patient care.
- To add to the existing body of knowledge and develop insights to inform future practice, thinking, research and education.

Fore-structure 1.

Statement: Professional accountability can be compromised by targets.

Interpretation

Many government investigations have demonstrated that a target driven healthcare system can have serious consequences for patient care (Berwick, 2013; Keogh, 2013b). In the Francis report (2013), staff were reported to have been encouraged to manipulate the data to reduce the financial penalties that could result. It seems common practice for hospital trusts to engineer ways of avoiding penalties, such as moving patients to assessment wards to avoid breaching the A & E four-hour wait. This demonstrates historical, political and financial drivers and the effects these have upon nurses' professional accountability.

Fore-structure

I understood the need for targets when they were first introduced, as there was a situation that involved a limitless wait for patients in A & E departments. I also understand and can appreciate the usefulness of key performance indicators (KPIs), dashboards and other evaluation tools to monitor the quality of care and assess levels

of harm and risk to patients. However, the reliability of the data gathered is arguable and is linked to punitive measures, which result in hospital trusts being financially disadvantaged for providing negative results. My views on this would be to utilise these indicators in a more positive way, to evaluate and increase the quality of care provided. I also consider that financially driven healthcare can miss the actual target of providing good quality, patient centred care. I feel that by imposing targets and financial incentives, nurses are forced to 'cut corners' and rush in order to comply with their allocated workload. I consider this to be unsafe practice, which compromises nurses' responsibilities under the NMC code of professional standards (NMC, 2015a). From an emotional perspective, this focus on targets rather than patients has left me with a sense of anger and frustration, since the drivers of these initiatives have lost sight of the fundamental aim of improving patient care.

Fore-structure 2.

Statement: Professional accountability can be compromised by inadequate staffing levels.

Interpretation

The majority of government investigations into failures in healthcare provision have reported that inadequate staffing levels have been a central concern. The Francis report (2013) recommended that all hospitals must publish the staffing levels on each ward and that minimum levels must be adhered to, but failed to align these recommendations to primary care settings. The fact that inadequate staffing levels has direct implications on patient care provision demonstrates the effects that historical, political and financial drivers have upon nurses' professional accountability.

Fore-structure

The recommendations from the Francis report (2013) were long awaited, and were implemented following a lengthy investigation into a distressing and often preventable series of events. However, the recommendations for minimum staffing levels are now used as the optimum levels, thereby making them the maximum level of staffing as well. The recommendations also failed to make these levels compulsory in primary

care, allowing a disparity in service-led agreement. It would appear that there needs to be an equity in staffing regulations in primary care, to prevent nurses' professional accountability being compromised. Having been a clinical practitioner for many years, the effects of inadequate staffing levels has had personal consequences upon my nursing career. I have witnessed nurses good and compassionate nurses, face emotional burnout because they could no longer cope with the excessive workload demands imposed upon them. I personally have felt a sense of frustration that despite evidence from public investigations and research studies, this most basic care provision has not been completely addressed.

Fore-structure 3.

Statement: Professional accountability can be compromised by excessive paperwork, which is compounded by no unified IT system operating across the whole health economy.

Interpretation

Over the past decade, the UK has become a more litigious society, with greater emphasis placed upon precautionary measures to avoid liability arising in a potential dispute. Such a situation clearly demonstrates the 'compensation culture' that is in operation. In light of the fact there is no unified information technology (IT) system that operates nationally and joins health and social care, nurses frequently have to duplicate manually written records, proformas and generate paper forms. Nurses can be professionally compromised by not always being in receipt of information and records in their entirety, and by not having enough time to complete legally robust records.

Fore-structure

The nature of health care means that there will always be a level of risk, but the adoption of defensive or over-precautionary practices can have a detrimental effect on patients and staff. A healthcare system needs to demonstrate that it has taken reasonable precautions. The IT system across health and social care needs to be a national unified system. I consider that the current system has the potential to be

unsafe, as it fails to adequately join health and social care, and acute and primary care settings. There is also no provision to allow nursing and residential care settings to access either health or social care data, leaving them isolated from necessary patient information. I acknowledge the complex nature of the IT debate in respect of data sharing, but feel that the lack of information sharing and wasted resources spent in duplication can seriously impact nurses' professional accountability.

Fore-structure 4.

Statement: Professional accountability can be compromised by nurses feeling too frightened to raise concerns as they fear the consequences of such action.

Interpretation

With reference to Table 2 in Chapter Two of this thesis, there have been many government investigations reporting an atmosphere of fear within the NHS and that staff were afraid of the potential adverse repercussions of whistleblowing (Winterbourne, 2012; Berwick, 2013; Francis, 2013; Kirkup, 2015). These aforementioned reports claimed that the culture of the NHS was perceived as a blame culture, and recommended there needed to be a shift in cultural behaviour, and a zero tolerance of poor standards. A new whistleblowing policy was introduced as a result of the investigations to encourage staff to raise concerns (Francis, 2013).

Fore-structure

It seems to me, that there remains a blame culture in the NHS, and there needs to be change in cultural behaviour from the top down to establish a more just and fair culture, which is more respectful and kind to nurses. I feel the negative culture makes nurses afraid of making mistakes and of raising concerns. Furthermore, I feel the existence of this negative culture has adverse effects upon the ways in which collegiality functions, and can lead to nurses treating their colleagues and junior staff with negative behaviours such as bullying.

Fore-structure 5.

Statement: Professional accountability can be compromised by lack of time to provide clinical nursing care activities.

Interpretation

The political and financial pressures placed upon the NHS, both in the public and private sector, are complex and are observed to be worsening, as the impact of an ageing population produces increased health needs. There is also an increased amount of regulatory pressure and scrutiny upon both public and private health care. The national decline in the number of qualified nurses is being worsened by the reduction in the number of commissioned student places that may be compounded by the introduction of student loans for student nurses (RCN, 2017a). The effects of recent immigration legislation has resulted in a reduced number of overseas nurses entering the UK and an increased number of nurses leaving the UK, a situation which may be further compounded by Brexit (RCN, 2017a). Moreover, one third of the nursing population is over 50 years of age, and will be wishing to retire in the next 10 to 15 years (RCN, 2017a).

Fore-structure

The effects of nurse shortages, in combination with increased workload, increased paperwork and greater regulatory pressures mean that nurses have less time to provide clinical nursing care activities. Furthermore, the key drivers of student nurse training, immigration and retirement mean that the future prospects for nursing will worsen following new government legislation. The workforce plan set out in the Care Act 2014 (legislation.gov.uk, 2014) established Health Education England in 2015, a non-departmental public body for this precise role, with the aim of addressing the issues of health, quality and financial sustainability in the NHS. There are currently 40,000 vacant nurse posts in England (RCN, 2017a). It is my understanding, that the combined pressures caused by the political, social and financial contexts need urgent attention, with greater planning put into recruitment and staff retention. Nurses need to have a more supportive environment, with adequate staffing and adequate resources in order to give high quality patient care. Health Education England (2016)

acknowledges that greater intelligence is needed regarding staff retention, and the merits of staff feeling supported and valued.

Interpretation and understanding

The terms 'interpretation' and 'understanding' are central concepts in hermeneutic philosophy and as such will be the cornerstones of this study. Heidegger (1927/2010) asserts that the development of understanding is what we call interpretation, and conversely interpretation holds the potential to understanding. Indeed, Dreyfus (1991) concurs with this, suggesting that understanding comes from interpretation. Heidegger (1927/2010) emphasises that understanding is essential, as *Dasein* does not exist without there being an understanding of *Dasein*. In the process of interpretation, Heidegger (1927/2010) likens this to 'unveiling', by which he meant to see clearly what was already there. The first stage of interpretation is referred to by Heidegger (1927/2010) as 'fore-sight' and he describes this as 'taking the first cut' (*anschneidet*). This fore-sight is intended to guide our approach and focus our thinking into what is to be unveiled in the text. Fore-sight informs our fore-having, determining our sense of being. Lastly is fore-conception ('fore-grasp'), which is closely linked to fore-sight and becomes apparent through discourse. Furthermore, Gadamer (1975/1996) asserts that language is central to our understanding as it has the potential to change our perspectives. Bontekoe (1996:123) adds that language 'shapes our expectations and our dealings with things in the world'. In order to embed this notion of understanding and interpretation into this research study, I made visible my own preconceptions, and as the research process developed and unfolded I continued to discuss my interpretations and understandings of the text. As Heidegger (1927/2010) points out, there is a necessity to uncover the taken for granted background practices present in participants' *lifeworld* to uncover what is already present, but unseen, allowing for new perspectives to develop. Additionally, it was important that I acknowledged any changes to my preconceptions and re-engaged with the hermeneutic circle to deepen my understandings, looking at the parts that make the whole and vice versa. I now focus this discussion on the specific phenomenon I explored, that of the *lifeworld* of the nurse pertaining to professional accountability.

The experience of *being* in professional accountability

By using the philosophy of Heidegger (1927/2010), I sought to discover how nurses' experience *being* in relation to their professional accountability, derived from the thoughts, feelings and perceptions of the participant's experience of professional accountability. Heidegger (1927/2010) uses the concept of *logos* (λόγος) to describe the process of interpretation using discourse. The function of *logos* allows something that is present to be seen, through talking or writing. Heidegger (1927/2010) adds a note of caution to this process, however, by observing some of the difficulties that could present themselves, noting *Dasein* is encased within the *everyday*. By this Heidegger (1927/2010) means that what is ontologically the nearest is also the farthest away. So to understand *Dasein* we must look at the *everyday*.

Benner and Wrubel (1989) observe that meaning comes from the individual making sense of what happens. As a researcher, my interpretations uncover meanings individual to me, and may differ from another's view of the same text. Nonetheless, both *being* and meaning are subjective, and understanding is unique to the individual who experiences the phenomena. For Heidegger (1927/2010), the essence of *Dasein* lies in its *being*, the very process of existing in the world. Heidegger (1927/2010) suggests that in order to understand the process of being we must look back at our experiences, describing *being* by describing what it was like, what it felt like, including the everydayness of the experience. In this study I explore participants' feelings of what it is like *to be* a nurse in relation to their own professional accountability. I present exemplars of the text to demonstrate how the participants experience *being* and meaning in their individual *lifeworld*, and how they themselves make sense of their experiences. Dreyfus (1991) adds that the context of *being* will be revealed through the background of social and historical and cultural shared practices. Gadamer (1975/1996) further observes that understanding *being* comes through our engagement with discourse and text, to make existence more meaningful.

Maintaining quality through rigour

Rigour is a concept used to describe the quality of the research process, with a more rigorous research process resulting in more trustworthy findings. Van Manen (1990) argues that because hermeneutics is a pedagogic practice, quality should be judged by the four standards of rigour: strength, richness, orientation and depth. Van Manen (1990) explains that the strength of the study refers to the capacity of the text to represent the principle intention of the meaning and understanding of the participant's story as expressed by the researcher. Richness refers to the aesthetic quality of the text, which is used to depict the perceptions of participants. Orientation concerns the involvement of the researcher in the world of the participant. Finally, depth is described as the ability of the text used to describe and illuminate the participants' meanings as perceived by the participants (van Manen, 1990).

Langridge (2007) asserts that member checking, or participant feedback, is an essential element of analytical rigour. Analytical rigour is the ability and actions of the researcher to note the true findings, which either confirm or disconfirm themes. It is important in phenomenological research that attention is paid to the rhetoric used throughout the study. Firestone (1987) describes rhetoric as the art of speaking and writing effectively. Koch (2006) adds that researchers demonstrate trustworthiness by depicting a clear audit trail of the research process and researcher reflexivity. Furthermore, Guba and Lincoln (1999) assert that trustworthiness is comprised of credibility, transferability, dependability and conformability. Guba and Lincoln's (1989) criterion describes credibility as occurring when the researcher's descriptions are faithful to the participants' text and the interpretation explained, combined with the researcher's reflections and thoughts. Credibility is further enhanced by verbatim quotes from participants (Tobin and Begley, 2004). Dependability is depicted as a concise audit trail, detailing the stages of the researcher's study. Lastly Guba and Lincoln (1989) refer to transferability, when findings can be transferred between contexts, depending on the parallels between the contexts. Transferability is taken by Koch (2006) and Sandelowski (1986) as 'fittingness' when study findings are seen to 'fit' into comparable settings, and those findings can apply to a reader's own experiences and be seen as being meaningful.

Having presented several definitions of quality or rigour, I now describe how in my view I have met the criteria involved. Firstly, I have described the research process that I have followed, detailing my thought processes and decisions in terms of the literature, which I have accessed in order to take certain procedural routes. I would refer in particular to my decision-making processes in terms of interviews and methodological process. I have made clear my own *fore-structures* and preunderstandings, returning to these ideas throughout the process, and describing my own emotions and thoughts as they occurred. By keeping a reflective journal and telling stories of my own experiences I have allowed the reader to see my interpretations and how I have influenced the data and how the data has influenced me. I have been concerned throughout that the study would become a narcissistic process, which has at times tempered my resolve to add more of my voice. It is for the reader now to make this judgement, although I feel self-assured in this. I have presented vignettes from the interviews, which I personally transcribed, again demonstrating my credibility, truthfulness and integrity to the process and the text. My positioning and orientation, as a nurse and a researcher, has been shown by the interaction I have had with the text, and the sharing of personal experiences. I have also remained true to the values and theories of Heidegger (1927/2010) and utilised his writings to interpret the text and analyse the data. In demonstrating a sound knowledge of the philosophy that underpins this study, and concise and clear explanations of hermeneutics and its value to nursing research, this thesis will enlighten other researchers to its significance.

Chapter Five: The Research Process

Overview

This chapter discusses the research process that has been followed and presents the mandatory and practical aspects adhered to in this study. In detailing the approach to ethical considerations, data protection and selecting participants, I provide a decision trail for the reader. The research process is in keeping with the study's methodology and linked to the philosophical approach. This chapter also gives the reader an introduction to the participants who were recruited to the study and gives a brief insight into their nursing careers.

Introduction

The research process adhered to is presented in this chapter, allowing the reader to follow the journey and process that underpin this study. Koch (2006) advocates that researchers should leave a clear decision trail for the reader to follow to establish trustworthiness. Polit and Beck (2010) concur with this, suggesting that by detailing the process and decisions made, the researcher adds transparency to the research. Furthermore, Patterson and Higgs (2005) assert that the openness of the researcher in a hermeneutic inquiry can make valuable contributions to the trustworthiness and transparency of study findings.

Ethical approval

The study gained ethical approval from the Manchester Metropolitan University Research and Ethics committee and local NHS trust research and development committee (Appendix 1 and 2). The standards for good quality research are set out by The Research Governance Framework for Health and Social Care (DH, 2013) and require that researchers seek ethical approval to ensure that the rights, dignity, safety and wellbeing of all participants must be the primary consideration in any research study. The Framework also requires that all participants give appropriate informed consent, and that this process is overseen by the ethical review process. An ethical approach was maintained at all times, promoting autonomy and ensuring the need to obtain data did not take priority over the needs, wishes and rights of the participants;

therefore, ensuring no participant was harmed (International Council of Nurses, 2012). To ensure the study was ethical in its approach, the study adhered to the following considerations.

Consent and right to withdraw

Prior to the study, participants were provided with written and verbal information about the study at least two weeks before the interviews took place (Appendix 3) and were encouraged to ask questions. Verbal and written informed consent was obtained prior to the commencement of all individual interviews (Appendix 4). All participants were informed that they had the right to withdraw from the study at any point before, during or after the individual interview. The focus of the study was to explore the experiences of nursing in relation to professional accountability. I therefore acknowledged that this could involve individuals discussing events that they felt were emotionally challenging or difficult. Participants could potentially feel vulnerable and anxious recalling these experiences. For this reason, it was made clear the study was for academic purposes and if any distress occurred during or after the interview, then the University distress policy would be adhered to and counselling would be made available (MMU, 2015). In retrospect, no distress was caused as a result of the interviews.

On reflection, I personally found the data collection experience challenging in that I could identify with many of the participants experiences. The process stirred up memories of specific situations which I had not wanted to think about, such as being bullied, or feeling humiliated or let down by people I depended upon. These recollections were written up in my reflective diary, and where appropriate are used alongside the participant's text. I admit that I have found it difficult to share some of these personal accounts. In part this was because the details were unfiltered and there was a risk of situations and people being recognised, but also due to the private nature of them, and the vulnerability which they uncovered. Indeed, I was unprepared and moved by the honesty that participants brought to the interviews, and shocked by the raw emotion evident in their stories when they detailed challenging situations they had encountered. The sense of astonishment I felt at the participants openness reflected my own insecurities of needing to keep emotion and vulnerability hidden, which I suspect originates from a skewed sense of professionalism and the idea of not

showing weakness. Certainly, I recall being told on many occasions not to let patients see that I was upset, or shocked, a mask which I must still carry in part at least.

Data protection

Data protection guidelines and recommendations from Manchester Metropolitan University and the local foundation trust research governance group were followed. The Data Protection Act (1998) highlights the need for all researchers to comply with the Act, in relation to data storage, access and management. These guidelines are echoed by the Research Council UK (2015). A method of coding to protect anonymity was used on all notes, transcripts and field notes. Each participant was assigned a unique code and pseudonym. All electronically produced documents pertinent to the study were saved onto a secure personal drive on the University server. The file was encrypted, and the password known only to the researcher. All tape recordings of interviews will be destroyed at the end of the study. The transcripts will be stored securely for five years, in line with government protocol before being destroyed (RCN, 2009). The data protection procedure was outlined to all participants

Risks, burdens and benefits

Risks, potential hazards or adverse effects on participants were considered and discussed with the supervisory team and acknowledged in the ethical approval application. It was felt that the main issue of concern was the potential distress which could be caused by participants disclosing an issue of concern. All participants were informed both verbally and in writing of the NMC (2015a) code of conduct involving disclosure of safeguarding issues and were also offered the opportunity of counselling, which was available through Manchester Metropolitan University via the Distress Policy (MMU, 2015). The University Distress Policy is a protocol designed to assist qualitative researchers in recognising and managing distress in interviewing or focus group activity. The protocol is adapted from the Burke-Draucker et al (2009) distress protocol. Because of the contentious nature of the research, there was a likelihood of distress occurring, but also the potential that the process could be cathartic as well. Following the interviews, several of the participants commented that they did indeed find the process valuable and cathartic.

Access to the field

Access was initially gained from a local NHS foundation trust site via the research and development department and head of nursing. I was also provided Good Clinical Practice training by the trust and granted initial access for six months followed by a further extension. I submitted all relevant information to the trust in order to obtain access permission. I made a conscious decision, which was supported by the supervisory team, to perform the research in an NHS trust I was not employed by as it was felt this safeguarded my own professional accountability and that of the participants. I feel not being known to participants allowed them to remain relaxed and uninhibited. If the research was carried out in my employing trust, participants may be influenced by what they thought I expected them to say, or feel inhibited by fear of repercussions, as I held a clinical management position at the time of the interviews. I realised from the pilot interview that participants may include colleagues and managers' names, and the fact that these names were unknown to me afforded participants a feeling of safety, summed up by the phrase used by the one of the participants: *'I can say their names so it makes it easier to tell the story, and it's easier because you don't know them'*.

My original intention was to send an email to all hospital nurses and all community nurses, with the assistance of the head of nursing to the chosen NHS foundation trust. This was agreed by the local research and development department and the researcher sent all the relevant information for dissemination to the nominated research and development officer. However, the response was slow over a six-month period despite follow-up emails. It was decided by myself and my supervisory team to make an amendment to the ethics board to seek an alternative channel of recruitment, via the University's continuing professional development (CPD) student cohorts. This meant that qualified nurses who were undertaking professional studies would be given the opportunity to volunteer to take part in the research. Following ethics board approval, an advert was circulated to all CPD students detailing the nature of the study. An immediate response was received from a number of qualified nurses. All interested parties were sent participant information sheets (Appendix 3) and consent forms (Appendix 4).

‘Sampling’ or ‘selecting participants’

The selection of the sampling method in any research study should be consistent with the aims and methodological approach (Cresswell, 2013). In a quantitative study it would be appropriate to achieve a broad spectrum of understanding, whilst a qualitative study seeks a depth and richness to its data (van Manen, 2014). Since the aim of qualitative research is to produce in-depth understanding of the phenomena in question, as experienced by the participants involved, individuals need to be purposefully selected according to Patton (2002). Furthermore, Cresswell and Plano-Clark (2011) add that purposeful selection of participants with experience of the phenomena allows researchers access to valuable information-rich data. On this basis participants were purposefully selected from qualified nurses working within the NHS. Scholars of phenomenology, however, feel that the term ‘sampling’ should not be used within a phenomenological approach, viewing it as an irrelevance of no significance in this paradigm (van Manen, 2014). Furthermore, van Manen (2014:352) states

The term sample should not refer to an empirical sample as a subset of a population. This use of the notion of sampling presupposes that one aims at empirical generalization, and that is impossible within a phenomenological methodology.’

Yin (2014) concurs with this view and observes that the term sampling implies an aim to obtain statistical generalisability, which is not in keeping with a phenomenological approach. Cresswell (2013) adds that the methods of sampling and analysis should reflect the philosophical principles of the research approach selected. The term ‘choosing informants’ is the terminology used by Cohen et al (2000:45); this use of language makes the point that individual people have been selected to inform the researcher. In order, therefore, that this study observes the philosophical underpinnings of hermeneutics, the term ‘selecting participants’ is used to describe how individual informants were recruited. I believe that this issue of appropriate terminology is of relevance to this study as Heidegger (1927/2010) places great significance on language and vocabulary. The purposefully selected participants had various nursing backgrounds, from hospital nurses to community nurses, and had been qualified from between 10 months and 35 years. Since this study is about looking

for meanings that are veiled within everydayness and embedded in life practices, it follows that participants should have experience of nursing and of being a nurse. No volunteers were stopped or excluded from participating in this study and all those that volunteered were interviewed.

Data collection

The intention of this study was to gather rich experiential data from the participants, by exploring their *lifeworld* and allowing insight into their perceptions and understanding of professional accountability. Data was collected by carrying out seven, individual in-depth interviews. It is generally agreed the issues of generalisability and representativeness are not an accepted concern in phenomenological research (Crotty, 1996). Therefore, the number of participants interviewed is generally low, commonly below 10 (Cresswell, 2013). Boyd (2001) advocates using from two to 10 participants. Morse (1994) advocates at least six participants is ideal in phenomenological research. This approximate number was echoed by Kuzel (1992) who observes that six to eight interviews was appropriate, whereas Creswell (1998) presents a more extensive range from five to 25 participants, but advocates a number below 10 if lengthy interviews are carried out.

Interviews are considered a principal method of data collection in phenomenological research as they afford researchers the opportunity to explore and illuminate participants' descriptions of the phenomena (Kvale and Brinkman, 2009). Heidegger (1927/2010) believes that inquiry should not just describe core concepts but look for meaning, which may be embedded in life practice. This study focuses on investigating individuals' experiences of *being-in-the-world* and *being* a nurse. A phenomenological study by Wilson (2014) demonstrates how this research approach was used to investigate the experiences of *being* a nurse mentor. Wilson's (2014) study gave a unique and sensitive understanding of the mentoring experience, exploring the essence of mentorship through the ideas of temporality, spatiality, corporeality and relationality.

When deciding upon the style of interview, I thought at great length about whether to choose an unstructured or semi-structured interview. An unstructured interview has its

roots in the traditions of anthropology and sociology and involves the use of one question offered at the commencement of the interview, with no prearranged questions, allowing an informal and spontaneous flow of information unstifled by questioning. This approach does, however, allow the interviewer to probe when there are areas of ambiguity to elucidate meaning and aid interpretation. Because I was investigating the everyday experiences of *being-in-the-world* for nurses working in the NHS and how they experience professional accountability, I decided to use certain probes to guide the interview. This technique allowed me to illuminate the phenomenon and give participants the opportunity to speak about things important and significant to them in their experience (Kvale, 1996). Heidegger (1927/2010) asserts that questioning increases our understanding and aids our interpretation. Cohen and Crabtree (2006) discuss the pros and cons of using a semi-structured interview technique, which I have reproduced in tabular form below.

Table 3: Advantages and disadvantages of using semi-structured interviews

| Taken from: Cohen and Crabtree (2006) Advantages | Disadvantages |
|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| Questions or topic headings can be prepared earlier, allowing the interviewer to be organised and appear proficient during the interview | Interviewing skills are required. Advanced preparation is required |
| Interviewees have the freedom to speak about their own experiences in their own words | Sufficient interviews need to be undertaken to make general comparisons |
| Provides reliable, comparable qualitative data | Risk questions being prescriptive or leading |
| Encourages a two-way communication process | Risk of construing too much |
| The information obtained may provide not just answers, but the reasons for the answers | Time consuming and resource intensive |
| Allows an opportunity to discuss sensitive issues | Discussing sensitive issues may lead to emotional responses and distress |

Using the above information as a point of reference, I decided I would adopt an in-depth, semi-structured approach, which would allow me to explore and engage in the process. A conversational style was promoted, encouraging participants not only to speak on topics that interested me as a researcher, but also to open up about things that were important to them (Silverman, 2013). Each interview began using an open question, enabling participants to speak freely about whatever they considered to be significant to them. The question I posed was '*could you tell me about your nursing career: The highs and the lows*'. I felt that by opening the interview in this way, participants would have the freedom to tell their story, and would highlight the events which had particular meaning to them. Indeed, this approach proved to be very valuable, and furnished the study with information I had not considered myself. An example of this would be when participants related experiences of their nurse training, and their interactions with peers. I suspect that this rich data may have been lost if I had adopted a direct line of questioning at the outset of the interview.

A topic guide made up of issues I felt were pertinent and based upon the preconceptions which I brought to the study was utilised in each interview to guide the conversations if needed (Appendix 5). The topic guide consisted of a number of headings, reflecting the aims of the study primarily and used as a prompt if needed (Gaskell, 2000) I did not feel there was a need to have a number of pre-arranged questions, as this would add too much structure and control the response too much. However, phrases I used to prompt or illuminate issues were responses such as 'Can you tell me more about that?' 'How did that make you feel?' I wished the interviews to be a shared communication process, which resulted in a cathartic experience and a trusting relationship being built up. Koch (1996) asserts that when carrying out interviews the interaction should be open in nature, with minimal direct questions being asked so as to encourage the interview process to remain as close to the lived experience as possible.

It was important that in order to gain insight into the phenomenon, I stayed true to Heidegger's (1927/2010) theory and discovered how the participants felt living through their experiences, as this concept upholds the belief that the person is seen as *being-in-the-world*, not as a separate entity of world. Heidegger (1927/2010) posits that the world is inseparable from the person because the world is both constituted by and

constitutive of the person (Leonard, 1994). The persons should be viewed as beings whose choices are integral to and therefore influenced by their *being-in-the-world*. Gadamer (1975/1996) observes that the basic hermeneutic question of 'What does it mean to be you living your life?' requires an understanding that is essential to *Dasein*. It is this understanding that increases our knowledge and allows us a grasp of self-interpretation and, as Heidegger (1927/2010) reminds us, is a confirmation of *being*. The goal, therefore, of these interviews and the subsequent interpretation was to grasp meaning from the *lifeworld* of the participants, and to engage in self-reflection and interpretation of myself and the world.

In casting a self-critical eye on my own interviewing approach, I acknowledge that I asked participants about their views on the 'no-blame culture' of the NHS. This proved to be an ambiguous question and very leading, prompting interviewees to tell me about how they perceived blame to be a part of the culture. Although valuable data was achieved through this question, I feel that my questioning was too direct, and I controlled the participants' narratives down a very specific path. Indeed, as Silverman (2013:206) points out, making respondents aware of your own interests can make for a 'lazy' form of research, in that their responses are too guided. Koch and Harrington (1989) assert that a self-critiquing approach is fundamental to reflexivity and conceptualising rigour.

Interview format/ procedure

When arranging the interviews with each of the participants, I asked them to inform me where the location of the interview would be most convenient for them. For safety reasons I did not wish to visit anyone at their home address, or at my home address, so I proposed that the interviews take place at either their workplace, Manchester Metropolitan University or at a health centre near to their home or work. On each occasion I offered to book private rooms within their chosen location. One interview took place in the University building, and six took place in their respective work settings. Prior to the commencement of the interview process, my choice of attire for the interviews was discussed with my supervisory team. This was a subject necessary for discussion, as I generally attended supervisory sessions in my hospital uniform and my uniform was very much my identity; however, if worn in an interview setting it

could have a substantial effect on participants. Fontana and Frey (1994) highlight the significance of selecting attire, and the influence this can have on the success of the interview. Raklow (2011) concurs with this, asserting that when interviewing certain groups of people, dress can affect the way in which participants react in interview settings. It was therefore decided that I would dress neutrally, and although participants knew that I was a nurse, they did not know my role or seniority, so that this would not influence the interview.

Each interview comprised the same opening and closing phases to demonstrate a consistent approach. The opening segment consisted of an introduction and recap of the study, confidentiality assurance, complaints procedure and explanation of the University's distress policy (Haigh and Witham, 2015). I also read out the consent form, before affirming the participants' understanding and asking them to sign it, reminding them that they could withdraw at any time should they wished to do so. Participants were thanked for their involvement in the study at the beginning and at the end. On closing the interview, the participant was reminded of the data protection rules surrounding their information and I gave them an opportunity to tell me how they were feeling, in case they felt distressed by any of the issues they had discussed. Two of the participants said that they had felt the interview had been cathartic; four indicated they had enjoyed it; and one described it as '*fine*'. None of the participants said they felt distressed or anxious as a result of the interview.

The interviews lasted between 45 and 90 minutes, with an average of 75 minutes across all seven interviews. All the interviews were audio taped, using a digital voice recorder, which is considered an appropriate choice in research so the data can be accurately transcribed (Kvale, 1996). The use of audiotaping is considered as one of the least intrusive forms of data collecting (Antle-May, 1991). It was also noted in the literature that researchers should be mindful that important information can be lost when the audio tape is switched off as farewells are being said (Antle-May, 1991). This situation did occur on one occasion and as I felt that the information was particularly relevant, I asked the participant for permission to include this information in the study, which they agreed to. All the audio taped interviews were transcribed by myself, and although a lengthy process aided the process of analysis and interpretation. Van Manen (1984) observes the importance of the researcher personally transcribing the

interviews as the very process of transcribing promotes a deeper understanding of the text and the phenomenon. Gadamer's (1975/1996) concepts on gaining understanding through dialogue and text underline the importance of this as he observes the significance of conversation and language. John and Johnson (2000) suggest that all the researcher's tools and software should reflect the methodological underpinnings of their research. I accepted that although computer software or the use of a transcription service could save time, it would not afford me the genuine interaction of dialogue and allow a deeper understanding of the text (van Manen, 1984; Gadamer, 1975/1996). I therefore resolved to personally transcribe the data, which I believe did enhance my understanding and allow a deeper exchange of knowledge.

Member checking

Member checking is a process whereby data, analytic categories, interpretations and conclusions are tested with members from whom the data is originally obtained. It can be completed as a formal or informal process, during the interview or in a written format following this, for instance by returning the transcripts of the interview. The purpose of this is to establish the validity and credibility of the individual's account (Lincoln and Guba, 1985; Creswell, 1998). According to Colaizzi (1978), researchers can ask participants, 'How do my descriptive results compare with your experiences?' or 'What aspects of your experience have I omitted?' In this way it provides the participant the opportunity to challenge the researcher's interpretation and thereby correct it. Lincoln and Guba (1985) suggest that this is a crucial technique in establishing credibility. It also allows the participant the opportunity to elaborate and provide further information and gives an opportunity for the researcher to summarise. In contrast Lillibridge et al (2002) comment that experiences described during an interview represent particular moments in time, and that to re-read a transcript detailing a past experience can cause anxiety and distress. It may also make participants feel a sense of regret at having disclosed personal information, or indeed may have forgotten what they had said (Sandelowski, 2002).

It is argued by Webb (2003) that member checking in phenomenological research is not considered as an appropriate course of action, as it is seeking to validate a description made by the researcher. If the participant does not validate it, it does not

make the researcher's findings invalid; it only adds another equally plausible description. Doyle (2007), however, feels that member checking has a place in interpretive phenomenology as the process of the researcher returning to the participant to discuss their interpretations ties in the two perspectives and adheres to the principles of the hermeneutic circle, moving between the text and the interpretation. Spiegelberg (1975) conceives this same process as 'cooperative exploration' likening the process to the psychiatrist and patient relationship, in which the psychiatrist sees the patient's experience through their eyes. Spiegelberg (1975) argues that the phenomenologist can only ever imagine the other person's world but can confirm this by checking. Van Manen (1990) suggests that once themes have been identified by the researcher, they can become subjects of reflection in follow-up conversations between the researcher and participant. This is a process that can be repeated several times. In order to fulfil the ethos of member checking, it was decided to give a summary of each participant in the form of a story, which would briefly describe each of the participants' experience and work life, with an identification of emerging themes. In this way each participant was able to verify that it was true to their own thoughts, and that way, my interpretation of their words would remain my research.

The participants involved in this study

Mel

Mel is a nurse in her forties who trained at a similar time to me. Mel had initially worked in an acute care setting before moving to primary care, where she has stayed for more than 20 years. Mel had experienced some work-related distress when she was part of an NHS restructure; this promoted strongly held negative views about the employing trust, which still employed her. The dominant concepts expressed in Mel's text were management, bullying and staffing.

Marie

Marie, who is a mature nurse, had completed her nurse training in the late 1970s. After qualifying she worked in an acute care setting for several years, before leaving to work in industry. A decade later she returned to nursing, which involved a return to practice

course. Initially she worked in acute care, before moving to primary care, where she currently works. Marie spoke about her experiences in her nurse training and the challenges she has encountered more recently. The dominant concepts that were expressed in Marie's text were nurse training, staffing levels, management and the culture of the NHS.

Jean

Jean is a nurse in her early fifties who started nursing when she was 21 after she had worked as an auxiliary nurse in a hospice. She said that her maturity, and her social position as a married woman, afforded her the respect of senior nurses and she admitted that this meant she was treated differently from the other, younger student nurses. After qualifying she worked in an acute care setting, before moving to the independent sector. Whilst retaining a job in the private sector, she also acquired two roles in the NHS, one in an advisory capacity and another in primary care. Jean spoke of the challenges to both the public and private sectors. The dominant concepts expressed in Jean's text were management, collegiality, professional development and staffing.

Adam

Adam is a nurse in his thirties who was born outside the UK and came to Britain several years ago; he has worked in the NHS in an acute care setting for the past 10 years. In his country of birth, Adam was one of only two male nurses in a cohort of 20 in his training. He commented that at that time, people did not recognise male nurses as professionals, treating them as untrained carers. Once qualified, Adam worked in an acute care setting and moved to the UK, continuing to practise in the same specialty. Adam currently holds a senior nurse position in an acute care setting. Dominant concepts expressed in Adam's text were management, whistleblowing and the NMC.

Gemma

Gemma is a nurse in her forties and had worked in both acute and primary care settings. She originally trained as a state enrolled nurse, before converting to a registered general nurse. She worked in acute care for several years, before

embarking on a career in primary care. She recently returned to an acute care setting. Gemma described her love for nursing and the ability to make a difference to patients' lives. Dominant concepts expressed in Gemma's text were management, staffing and whistleblowing.

Dawn

Dawn is a nurse in her early thirties who trained outside the UK. On qualifying she worked in both acute and primary care settings. She found the culture of nursing and the poor public perception of nursing in her native country difficult to deal with and decided to move to the UK. She has worked in an acute care setting in the UK for a number of years. Dawn was extremely interested in my study and in the methodology that I had selected, as she was also engaged in post graduate studies. Dominant concepts expressed in Dawn's text were peer support, management and culture.

Caroline

Caroline is a newly qualified nurse in her early twenties. On qualifying she had secured a post in primary care, having encountered very positive experiences of this setting during her student nurse training. However, whilst still on her preceptorship programme she decided to apply for a position as a staff nurse in acute care, due to the poor staffing levels and high workload she experienced in primary care. Dominant concepts expressed in Caroline's text were the stresses of becoming a qualified nurse, peer support, staffing levels and culture.

Table 4: Participants involved in the study

| Pseudonym | Age Range | Time qualified | Nursing experience and present role |
|------------------|------------------|-----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mel | 40–50 | 25 years | Mel had worked in the primary care setting for over 20 years. At the time of the interview, Mel worked as a senior nurse in primary care. |
| Marie | 60–65 | 35 years | Marie worked in an acute care setting for several years after qualifying. She left nursing to work in industry before returning to nursing 15 years ago. At the time of the interview Marie worked as a senior nurse in a primary care setting. |
| Jean | 50–60 | 28 years | After qualifying, Jean worked in acute care before leaving the NHS to work in private health care. Jean returned to the NHS five years ago. At the time of the interview, Jean was employed in three part-time jobs, one in private health care and two roles in primary care. |
| Adam | 30–40 | 15 years | Adam qualified as a nurse outside the UK. He moved to the UK several years ago. At the time of the interview he worked as a senior nurse in an acute care setting. |
| Gemma | 40–50 | 21 years | Gemma had experience of working in both acute and primary care. At the time of the interview, Gemma worked as a staff nurse in acute care. |
| Dawn | 30–40 | 10 years | Dawn qualified outside the UK and worked in both primary and acute care settings. She came to the UK a few years ago and has worked in a senior role in an acute setting since. |

| | | | |
|----------|-------|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Caroline | 20–30 | 10 months | Caroline is a newly qualified staff nurse, initially working in the primary care setting, before moving to the acute care setting. At the time of the interview she worked as a staff nurse in acute care. |
|----------|-------|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

My approach to data analysis

My approach to data analysis was to explore the *lifeworld* of the participants. In Heideggerian terms, seeing things differently by uncovering the everyday, often taken for granted information that was present in the participants' texts. I utilised the hermeneutic circle and a reflexive approach to the data, to combine my own experiences with those of the participants to co-constitute the data (Heidegger, 1927/2010). By viewing the parts in relation to the whole and vice versa I managed to build upon my own interpretations and find new meanings. In bringing my own preconceptions to the fore of my consciousness, I was able to challenge my existing views against what the participants had experienced. Since the study was underpinned using Heideggerian philosophy, the intention was to view the data through a Heideggerian hermeneutical lens. Therefore, the essential concepts were seen in hermeneutical terms, relating to the understandings portrayed by Heidegger (1927/2010) in his writings. An example of this would be to see the way in which we interact with each other, in the Heideggerian concept of *being-with* (*Mitsein*).

Practical steps taken in the process of data analysis

From a practical perspective the recordings were listened to and transcribed, and re-listened to, in order to ensure the transcription was an accurate documentation of the participant's account. This was then annotated using field notes taken at the time of the interview (Appendix 6). The transcribed texts were read and re-read, again annotating the text and highlighting parts initially conceived as themes. Koch (2004) asserts the importance of this immersion in the data to generate context to the text. My initial thoughts on the themes that started to emerge changed as the analytical process developed. My original thoughts as I explored the data led me to consider themes such as nurse training, the NMC and leadership although this shifted as I

further explored the texts and saw that the insights being illuminated were different to my first thoughts. To explain this further; the experiences and feelings being voiced when participants talked about their nurse training, were relating to specific issues of fear, management, collegial relationships and culture. I focussed on these more specific issues and chose to articulate these as themes. Once the dominant themes were established, the texts were again searched for further evidence of the same concept. This approach demonstrates how the hermeneutic circle was utilised, by looking at the whole, the parts and then whole. Moreover, it was important that text was not isolated from the whole interview, as each individual part had to be in context with the participant's lifeworld.

Impact on organisation of data analysis

Patterns and themes were created by grouping the different experiences of the participants. It was important to me that differences were uncovered and not ignored because they lacked the commonality of others' voices. An example of this would be the comments of Adam and Gemma who spoke about self-protection in not wishing to report concerns. Although their comments were in contrast, their experiences brought a different perspective to the study, and one that could cast a new light on the phenomenon in question. The themes that emerged from the data are referred to as essential concepts, which was a term I decided would best convey their description and illuminate their contextual importance. I would argue that my specific use of language is important here, as Heidegger extolls the virtue of using applicable terminology. These essential concepts generated from the interviews are now presented, along with the process of data analysis taken.

Chapter Six: Data Analysis: The Essential Concepts

Overview

This chapter details the essential concepts that have emerged from the collected data and discusses them with reference to my own experiences and my changing perspectives. The data is then considered from a Heideggerian perspective, in an attempt to see different meanings and uncover new insights into the nurses' *lifeworld*. In co-constituting the data in this way, I will demonstrate credibility and rigour in remaining true to the data, and transparent in my interpretations.

Introduction

In this chapter I highlight concepts and meanings I felt were significant and arranged them into headings. Van Manen (1984) suggests this as a meaningful way of organising the information that has been gathered. I consider the purpose of this chapter as searching for what it means to *be a nurse*, in a Heideggerian hermeneutical sense with regards to the participants' experience of professional accountability. Heidegger (1927/2010) suggests that *Dasein* may manifest itself in two modes of *being*, which are *authenticity* and *inauthenticity*. The existential state of *Dasein* is exactly the interplay between these two modes of *being*. Therefore, I will endeavour to provide some insights into the *lifeworld* of nurses and how they experience professional accountability and modes of *being*. To understand what it means *to be a nurse* working in the NHS in the UK, there must be an appreciation of the historical, cultural, political and social constructs and traditions that underpin and affect our understanding, actions and meanings. The experience of *being* in the nurse's *lifeworld* affords us rich and deep insights into the phenomena, from both the perspective of the researcher and the participant. In studying our *lifeworld* experience, we are always looking retrospectively, but always intending to recreate a connection with the original experience (van Manen, 1975). The interpretation derived from the text is not intended to be the 'correct or definitive interpretation'. I acknowledge there may be many different interpretations, depending upon the preunderstandings and *fore-structures* of the interpreter. What is important is that my interpretation remains true to the data, as there is no absolute unchanging knowledge (Diekelmann, 1993). Several essential

concepts were evident in the interviews. I identified these concepts through a number of approaches: by commonality, by the strength of emotion expressed or the differences uncovered. Heidegger (1927/1962:58) describes the process of phenomenology as being ‘to let that which shows itself be seen from itself in the very way in which it shows itself from itself’. The following essential concepts, therefore, will explore how nurses experience *being* in relation to their professional accountability.

The essential concepts

Table 5 is a depiction of the essential concepts that emerged from the data, demonstrating their links to practice and their links to Heideggerian concepts:

Table 5: Essential concepts: links to practice and Heideggerian concepts

| Essential concept | Links to practice | Links to Heideggerian concepts |
|--------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. The culture of the NHS in its <i>being-in-the-world</i> | Historical, political, social contexts of culture Blame culture Incident reporting Staff feeling undervalued Lack of effective management Management is remote/inaccessible Excessive workload | Ontological characteristics of <i>Dasein</i> : <i>they-self, authentic self, inauthentic self</i> <i>World and worldhood</i> <i>Being-with (Mitsein)</i> How individuals interact with the world: <i>Vorhanden, Zuhanden</i> and <i>Unzuhanden</i> |
| 2. The existential constitution of ‘<i>the-there</i>’ | Fear of making mistakes Fear of new roles Fear of raising concerns | Fear as a mode of <i>attunement</i> Fear as a barrier to <i>authenticity</i> . How individuals interact with the world: <i>Vorhanden, Zuhanden</i> and <i>Unzuhanden</i> |
| 3. <i>Self-preservation</i> within the culture of the NHS | Raising concerns is a futile exercise | <i>They-self, authentic self</i> <i>Dasein’s call to itself</i> <i>Priori perceptions</i> |
| 4. <i>Being-with (Mitsein)</i> Positive collegial relationships in <i>being-in-</i> | Collegiality Organisational culture Lack of support from clinical managers | <i>Being-with (Mitsein)</i> <i>Dwelling</i> <i>Concern and solicitude</i> |

| | | |
|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>the-world</i> relating to the nurses' lifeworld | Team working | |
| 5. <i>Being-with (Mitsein)</i> Negative collegial relationships in <i>being-in-the-world</i> relating to the nurses' lifeworld | Bullying/horizontal violence Negative managerial input | <i>Being-with (Mitsein)</i> <i>Dwelling</i> <i>Concern and solicitude</i> |
| 6. <i>Care and solicitude</i> in nursing and its effects upon nursing care | Factors affecting patient care Low staffing Insufficient time Lengthy/repetitive paperwork IT systems | <i>Care structure: throwness, fallenness, authenticity</i> <i>Care, concern and solicitude.</i> |
| 7. Management in nursing | Lack of effective management Low staffing Blame culture Poor IT/excess paperwork | <i>The-they, they-self</i> <i>Solicitude</i> <i>Leaping-in</i> <i>Leaping-ahead</i> |
| 8. Professional accountability in nursing | Professional accountability Challenges to nursing practice Compassionate care Holistic care as non-negotiable part of nursing Emotional labour in nursing | <i>Care structure: concept of solicitude and concern for others</i> <i>Being-with</i> <i>Facticity of throwness, projection (Entwurf)</i> <i>An authentic mode of being</i> <i>Attunement/mood (Befindlichkeit) and understanding (Versehen)</i> <i>Dasein's realising potentiality</i> |

The essential concepts that emerged from the data are very much inter-related and each are complex issues in their own right. The first essential concept was the culture of the NHS, in its *being-in-the-world*. This concept is in many ways a central issue, which has links to the other concepts as well. Ontologically this concept examines the ways in which *Dasein* relates and interacts with the world, taking into account the historical and socio-economic contexts that surround it. The second concept is that of fear and relates to individuals' experience of this mode of attunement (Heidegger, 1927/2010). The concept of fear is connected to the culture, and also relates to the third concept of self-protection. Self-protection is witnessed as a coping mechanism in

participants and relates to the Heideggerian notion of *authenticity* and the *they-self* (Heidegger, 1927/2010). The fourth and fifth essential concepts that emerged concern the ways individuals interact with each other *in-the-world*, in both positive and negative ways, using the Heideggerian notion of *being-with*, (*Mitsein*) (Heidegger, 1927/2010). The sixth essential concept is that of *care* and *solicitude* in nursing, which look at the impacts upon nursing care caused by compromises to individuals' professional accountability (Heidegger, 1927/2010). The seventh essential concept is the issue of management, which participants had experienced in their *lifeworld*. The subject of management was looked at through the Heideggerian notions of *the-they* and *solicitude* (Heidegger, 1927/2010). The last essential concept that emerged focuses on the participants' personal thoughts about the concept. This was examined using the idea of understanding through the Heideggerian *care structure* and modes of interaction in *being-in-the-world* (Heidegger, 1927/2010). By using a Heideggerian lens to explore the nurses' *lifeworld* new perspectives were gained and new insights found.

Essential Concept 1: The culture of the NHS in its *being-in-the-world*

Introduction

The overarching aim of this section is to explore the *being-in-the-world* of the participants, against the backdrop of the NHS. As a reflection of the hermeneutic circle, the parts are constituents of the whole, and the whole is a constituent of its parts. So the culture of the NHS is made up of the individuals who belong to it with ideals and values, which feed into it and from it. The culture experienced is swathed in historicity, political and social influences, and governed by rules and bureaucracy. The first essential concept in this chapter deals with how participants view the overall culture of the NHS in their own *being-in-the-world*, and how this impacts on their general *everyday* behaviour and choices. In the first essential concept, participants spoke of their feelings pertaining to the existence of a blame culture, and this was manifested if an incident arose in clinical practice. They articulated perceptions of being punished and scapegoated by managers, who looked to attribute blame to individuals. There was no mention of any learning arising from investigations. This made me consider if a blame culture culminated in, or indeed stemmed from, individuals' fear of making

mistakes. The fear that was described is discussed in the second essential concept, *the existential constitution of the-there* and takes account of the historical, social and political influences apparent in nursing.

A third essential concept follows this, relating to the ways in which two of the participants dealt with the issue of raising concerns. In this essential concept, I note that it is not fear that stops the participant's from raising concerns, but the motive of self-protection, a coping mechanism that is in some ways devoid of emotion, and conceived through a desire to keep oneself safe. The Heideggerian concept of *being-with*, denotes our relationship with others and how this affects our *being*, and is discussed in the third essential concept: self-preservation within the culture of the NHS. Using Heideggerian philosophy, I then look at the different ways the participants experience *being-with* others, in both positive and negative ways, in collegiality and conversely in bullying. By exploring the parts, which in this case are the individual relationships, it is hoped this will help to shed greater understanding upon the whole, and conversely the whole will aid understanding of the parts.

Essential Concept 1

This essential concept investigates how participants viewed the culture of the NHS and the challenging effects upon their respective *lifeworld*. The concept of being involved in a particular culture is discussed in this essential concept, and explores the culture of the NHS in its *being-in-the-world*. It adheres to the aims of this study by exploring the perceptions and insights of participants' experience of the culture of the NHS in terms of their own individual and professional accountability, and the impacts upon patient care. My own observations on the culture of the NHS resemble closely those found in the many contemporary government investigations, which recognise the existence of a blame culture (Berwick, 2013; Francis, 2013; Kirkup, 2015). Essential concept 1 (the culture of the NHS in its *being-in-the-world*) is grounded in the study findings and incorporates various aspects of culture. First, I explore the concept of the existence of a blame culture, before looking at the individual aspects of culture, relating to inter-personal relationships, in both their positive and negative facets. Using a hermeneutical lens, I use the philosophy of Heidegger (1927/2010)

and the concepts relating to *Dasein* to observe how individuals interact with one another.

The concept of culture from an organisational perspective relates to the Heideggerian idea of *world* and *worldhood*. Heidegger (1927/2010) makes the observation that *Dasein* often overlooks the concept of *worldhood*, and this omission is a crucial mistake in the quest for hermeneutic understanding. He acknowledges the notion of *world* as comprising entities that exist in the world, which can be categorised and described such as houses, people and mountains (Heidegger, 1927/2010:63). Furthermore, he rejects Descartes' subject/object view of how we interact with the world, instead Heidegger (1927/2010) sees *Dasein* as inextricably *being-in-the-world*. When discussing the concept of *worldhood*, he divides this into parts. Our environment (*Umwelt*) is our everyday surrounding world, which is made up of things and other entities that are useful or of value to us. In exploring *Dasein*, we look at our everyday comportment, which is the way we treat and behave towards things and entities. This brings us back to the earlier descriptions made in Chapter Three concerning our modes of comportment, which are; *Vorhanden* (present-at-hand), *Zuhanden* (ready-to-hand) and *Unzuhanden* (unready-to-hand). *Worldhood*, therefore, is a characteristic of *Dasein* as well as the place where *Dasein* exists ontologically, along with the broader view of the totality of entities.

Using the hermeneutic lens, I now explore the participants' experience of the culture of the NHS as they perceived it and the influences it has had upon their practice and decisions. In each interview, I asked the participants if they felt the NHS was a 'no-blame culture'. This choice of phrase turned out to be ambiguous to some. With hindsight, this question could have been reworded, or removed entirely, to allow more impartiality, a point that I reflected upon earlier, in Chapter Four, and perhaps has been influenced by my own historicity in working in the NHS. Here are several of the answers to this question:

Gemma

No, No it's not no blame. If something happens the first thing they look for is someone to blame. They will always scapegoat someone. The layers of bureaucracy since the Francis report has worsened, with more paperwork.

They can say well this wasn't done so it's this person's fault. No one ever wants to make a mistake, not in their wildest dreams do they. When I was working in the [primary care service] we recorded everything, KPI's, Lorenzo, everything. I used to say to my managers I would love you to put a gadget on my back and record everything I do and say to my patients, you can listen to everything. I would rather that than make me fill all this in... I felt that I needed to keep good records, but we are forced into bad habits, which I think was unsafe. We didn't have time to keep good records. They would say "you have to make time. You have to prioritise". This is the blame culture. It is always passed back to you. It is up to you to prioritise. It is up to you to keep good records. But where does the time come from? You are at fault because you can't prioritise. (Gemma: staff nurse: acute care)

Gemma went on to speak about the seemingly bureaucratic nature of record keeping, when it seems to be more of a managerial performance management tool than for the good of the patient. She discussed the aftermath of the Francis report (2013):

The health authority have met this by putting another layer of paperwork there, so they can say yes we have done this or that; they can tick the boxes without actually looking at the patient. The nurse can go through the checklist yet couldn't tell you what hair colour they have. It's too bureaucratic now. (Gemma: staff nurse: acute care)

In the first exemplar, Gemma was quite pointed in her response to my question. She emphasised the word 'no' twice, to reinforce the fact that she did not consider it a 'no-blame' culture. She then said, '*If something happens the first thing they look for is someone to blame*', which conferred that she had experience of that occurring. The word 'scapegoat' was used to describe the person who was held responsible for the wrongdoing, which conjures up imagery of the accused person becoming victim-like. Gemma's use of words made me feel that in her opinion, the 'scapegoat' is someone who is being judged and convicted unjustly. Perhaps she was questioning the 'rules' of the culture. She went on to say that the aftermath of the Mid Staffordshire inquiry (Francis, 2013) meant there was more paperwork to fill in, becoming more bureaucratic, and making individuals more accountable. She used the term *they*, to

refer to the management of the organisation, and this was also reflective of Heidegger's (1927/2010) reference to *the-they*. Her text denoted a clear 'us and them' situation, with *the-they* looking for someone to blame when '*things happen*', which referred to when an incident occurred.

The idea of an audit trail, which I assume she was referring to in '*the layers of paperwork*', should have been seen as a positive addition, to allow the management to trace back to what had occurred, and find a solution to prevent a further incident from happening. Instead, Gemma believed that it was orchestrated and acted upon in a judgemental manner, allowing it to be seen as irrelevant bureaucracy, which sought to apportion responsibility and blame. Gemma observed there was insufficient time allocated to complete comprehensive records when she worked in primary care. She again refers to the blaming culture, which she felt manifested itself when things went wrong, and notes were investigated. She described the challenges and conflicts of trying to prioritise when workloads were excessive. Her comment, '*It is always passed back to you. It is up to you to prioritise*', is suggestive that she had asked for help but the decisions had been left to her to make.

Gemma was very direct in her assertions, and I felt very uncomfortable at much of the content of her interview, as she described how she experienced being a nurse. My discomfort was prompted by listening to how she had been treated by managers when she requested assistance. I could relate to her feelings and interpreted her remarks to mean that the culture she was experiencing seemed unjust. In my reflective journal which was completed in the evening of the interview I wrote the following entry:

I am troubled by this afternoon's interview, and sad that her voice had not been heard. There always seems such a divide between management and frontline staff, and this creates so many problems. As a manager myself, I feel a sense of embarrassment that managers are seen in this negative light all the time, as if this is a reflection upon me. The reason I took the role was to try to make a difference, to do things differently. Gemma seems so committed to making a difference, yet is blocked at every turn, and I get the feeling that perhaps she is becoming resigned to the situation.

Adam

Adam offers a similar view on the existence of a blame culture then added to this by discussing the valuing of staff;

Well they say it's a no-blame culture, but it IS [emphasis on the word 'is'] a blame culture [laughs] the blame culture is there. The NHS has changed since I came into it 10 years ago. They don't treat staff well. They don't value staff. When I came in we used to be given tea and coffee. Now there is nothing given to us. We have to buy everything. It's a small thing but people notice it. I don't even drink tea and coffee, but that's a symbol of treating people with some worth, some respect. Thanking them for their hard work... No one goes into nursing to make mistakes and do wrong. Nurses come into this job to give good care to patients. They just want to give good care. (Adam: senior nurse: acute care)

Adam seemed quite annoyed when describing the culture of the NHS as a blame culture. He visualised blame as being its own entity, by saying '*the blame culture is there*'. He also identified that he felt staff were not valued. He mentioned that staff have to purchase their own tea and coffee, which he admitted was only a small thing, but the principle of having this supplied made him feel valued. I reflected upon Adam's text and thought about my own career, in which I always tried to maintain a positive attitude, and display gratitude to others. Perhaps this stems from the fact that I have always been motivated by the knowledge that others appreciated me and the difference to my morale when I have felt unappreciated. Adam alludes to staff feeling they were dispensable, adding to the perceived low morale of the organisation. Adam asserted, '*they don't treat staff well. They don't value staff*', immediately after his thoughts on the blame culture. It would seem that staff feeling valued has a close correlation to a blame culture and they are perhaps interlinked. The use of the word '*they*', is in reference to the organisational leadership, and is reflective of Heidegger's (1927/2010) *the-they* as those controlling the establishment. Adam also made a similar comment to Gemma, in saying that '*no one goes into nursing to make mistakes and do wrong*', summing up the good intentions of nurses, who fundamentally '*just want to*

give good care'. Although this connects to the issue of blame, it also embodies the altruistic ethos of nursing, as a dedicated and caring profession.

Dawn

Are you asking me if it is a no-blame culture? No it is not. It is the opposite. If an incident happens it definitely finds blame. We fill in incident forms; we reflect on it; we feel like we are punished. (Dawn: senior nurse: acute care)

Dawn's response was brief, yet concise. She appeared to have not heard the expression of a no-blame culture, so clarified the question, before answering it. She outlined the series of events that occur when an incident happens, ending with the sentence '*we feel like we are punished*'. Like Gemma, her response similarly inferred it felt unjust and unfair that blame was attributed to an individual nurse. It was interesting that the notion of punishment was evident following reflective practice, which should have been a learning process. There is no discussion on education arising from the incident or changing practice, policy or system management. Gemma stated, '*If an incident happens it definitely finds blame*'. This again reflected Gemma's imagery of scapegoating and finding someone to blame. The imagery used here of the incident finding *blame* is also interesting, suggesting that *blame* is something that would inevitably occur.

Caroline

Do you mean a blame culture? Or a no-blame culture? I haven't heard that expression. Well it's a blame culture all the way isn't it? [Pause] If you had asked me this a year ago, I might have given you a different answer as I found [location] quite good, or perhaps I just didn't pick up on it that much because I was a student. But here, it's terrible. If you do something wrong, you tell your line manager, fill in a DATIX report and then it all hits the fan so to speak. When I was at [location] three nurses had all made a minor error and they were all crucified for it [pause]. It was complete overkill [pause]. It broke them all. They will never have the same confidence. (Caroline: newly qualified staff nurse)

Me: '*It sounds like it was a really upsetting situation*'

Caroline

Yes it was, it was awful. It happened to all three of them because they were rushing. We are all rushing from one patient to another. You don't have time. [Pause] (Caroline: newly qualified staff nurse)

Me: *'That must worry you?'*

Caroline

Yes it is a worry. [Pause] its constant [Pause] (Caroline: newly qualified staff nurse)

Caroline was silent for a short while, and I did not interrupt with a further question, as I felt she needed this lull in the interview to compose her thoughts. I felt this was a significant worry, which perhaps dominated her everyday life of *being* a nurse. After this pause she continued:

Caroline

We have no time to write proper notes. It's ok saying you must write comprehensive notes, which could be used in a court of law, we all know that, but where does the time come from ? (Caroline: newly qualified staff nurse)

Me: *It sounds like you feel really compromised, not having enough time to give care and write up notes. How do you think you will deal with this?*

Caroline

I don't know really, I suppose that's why I moved to [Acute care setting] I just don't know where the time is supposed to come from. I loved the community, but it's just too stressful, or I'm not quick enough [Pause] No, everyone else was rushed, so its not just me [Laugh] (Caroline: newly qualified staff nurse)

Caroline, like Dawn had not heard the phrase no-blame culture, and quickly corrected the phrase into blame culture. She reflected that her views had changed since qualifying and considers whether it was her student status or the location in which she

completed her training that had afforded her protection from witnessing this negative culture. She had a clear understanding of the process of reporting incidents, which appeared to herald from working in a particular primary care setting. She shared her experience of seeing three nurses being held to account for minor errors. Her opinion of the way it was dealt with was '*complete overkill*', which I assume means they were performance managed in some way, and she had witnessed their distress and anxiety, when she says, '*It broke them all*'. She had also witnessed their loss of confidence within their role, which she attributed to the way in which the incident had been dealt with. The fact that she was well aware of the distress, details of the incident and managerial behaviour surrounding it, implied the events had taken place in a somewhat public arena and it had possibly created distress to many people in that environment. It seems the impact of poorly managed incidents creates lasting ripples for some time within the practice environment. Caroline then went on to state that she did not feel she was given adequate time to address the issue of effective record keeping. There is a clear sense of anxiety between knowing what she needs to do and the reality of not having enough time to complete it. As a newly qualified nurse, her acute awareness of her responsibilities and accountability to the NMC and the NHS is evident along with knowledge that her accountability is being compromised. The fact that she had witnessed at first-hand how nurses can be made accountable for their actions in a public and seemingly harsh manner, accentuated her anxiety about her own safety and made it more tangible in her text. Caroline acknowledged her own inability to cope with these pressures, and the decision she took to move from a community setting to an acute care setting, which was less autonomous, and afforded her more support. At one point of the interview, she questions whether it was her own inadequacy, in being '*not quick enough*' but correcting this after a moment's thought, realising that everyone was '*rushed*'. Caroline's thoughts reflected similar issues which were being experienced by other participant's. In Jean's text she looks at these issues from a more objective stance, an account which is less emotionally driven than that of Caroline's.

Jean

There is a blame culture. Mistakes are generally down to system failures in my opinion. We always had emergency case scenarios, life support, and so on. I

used to always think that the nurses felt under pressure, as if they were being watched, criticised. I always tried to make it a learning exercise, not a blaming exercise. (Jean: multiple roles)

Jean firstly testified to the existence of a blame culture, but then said, '*Mistakes are generally down to system failures in my opinion*', which is a more complex and holistic view than the other participant's. Her text also reflected upon her experience as a manager where she tried to remove the concept of blame and make the focus on learning. Jean's thoughts were much less emotive than the others' in so far as she was concerned about how the existence of a blame culture negatively impacts other staff. She had witnessed how staff react to feeling pressurised, so implemented change herself, to create a learning environment. My own feelings reflected Jean's thoughts and attitudes concerning this, and I shared her view that most incidents appear linked to system failures, and usually had mitigating circumstances attached to them. As a manager in primary care, when I investigated incidents I was frequently told by staff that they felt the incident would not have occurred if they had not felt pressurised and rushed, or if new policies had been implemented, they had not been accompanied by adequate training.

The participant's texts related the issue of blame to the situation of a nurse making a mistake. The words '*mistake*', '*punishment*', '*blame*' and '*crucified*' were used to describe these circumstances. All these words are powerful terms and have an association with suffering and distress. Both Adam and Gemma picked up on the fact there was no intentionality behind errors that occur and that individuals come into nursing to care for patients, a point also made by Berwick (2013). There was general agreement in the texts above that they had observed a situation in which managers tried to identify individuals to apportion responsibility for any mistakes that occurred. Gemma asserted that, '*they look for someone to blame*', and Dawn further noted that, '*If an incident happens it definitely finds blame*'.

Heidegger (1927/2010) articulates praise and blame as being separate from the idea of characteristics of personal choice, observing that these two actions, along with reward and punishment, come from the individual's conscience. Heidegger (1927/2010) emphasises that conscience is not a function of praising or blaming;

instead, conscience has the ability to change the inauthentic *they-self* into an authentic self, which can select commitments autonomously. 'The call of conscience, is a call of Dasein to itself', and as such a call to one's *authentic* possibilities (Heidegger, 1927/2010:275). When the participants talked about blame, it was with reference to a nurse being blamed for an incident or event, as their experience suggested this would occur. Most of the participants voiced that their experience of culture was one which was fuelled by blame and the need to find someone specifically accountable when incidents occurred. However, not all the participants viewed the present NHS culture in the same way, and Marie made the following comments to my question of whether the NHS was a no-blame culture. She made the direct comparison that in her view the culture had improved from one of fear, which is detailed in the next section, to a '*more open culture*':

Marie

The positive side of the NHS, which has changed, is that I think it's a far more open culture now. I think patients are encouraged to be more involved in their care and everything is supposed to be more patient focused. It's a long way from perfect, but I think it's better in that respect. (Marie: senior nurse: primary care)

Marie addressed the question in a different way, not giving a direct answer. Marie had perhaps witnessed more diversity within the NHS. Her other exemplars, which are discussed later in this chapter, recount a very rigid, oppressed culture in her early career in the late 1970s in comparison to contemporary practice. She saw the present culture as more open and more patient centred, allowing patients more involvement with their care planning. She stated the culture remained flawed, using the expression '*it's a long way from perfect, but I think it's better*'. She has compared the past with the present and made a definitive judgement. Later in her interview she described the '*long-hours culture of nursing*' caused by high workloads. She then went on to discuss the apparent futility of the reporting system:

Marie

Well you raise concerns about the workload, but it's just frustrating when nothing seems to happen to alleviate the concerns. I mean once we did involve the union at one stage about the problems of, you know, the stresses of work,

the long-hours culture which we seem to have. All unpaid. It really boils down to the fact that the reason we're working longer hours was because, you know, that there was too much work for the staff that were available. But that never really came to anything. It wasn't resolved. the union weren't able to push it forward and [pause] and I think we all just got fed up with it and the whole thing was dropped then. (Marie: senior nurse: primary care)

Me: *Was it quite difficult to raise concerns?*

Marie

Well, we did it as a group. We had to do it collectively really, because there were issues which affected all the service, and new staff came, and would leave because of the long hours, and the staffing issues. Plus you'd get people going off sick because they couldn't cope. We should have kept on with it really, but at the time we were just too tired. (Marie: senior nurse: primary care)

Marie described the normal everyday culture of her role in the primary care setting. She described the excessive workload through the expressions, '*stresses of work*', '*the long-hours culture*' and '*too much work for the staff that were available*'. Raising her concerns had also escalated to the involvement of the union, but even these serious measures had not brought about any change in the overall environment. Marie made no mention of being afraid of raising concerns, but points to the fact that she was part of a group, which I suspect would afford a greater sense of security when raising concerns. However it seems she had attempted to raise concerns personally about working conditions before involving the union in a collective approach, but both these strategies had proved fruitless. When interviewing Marie it seemed sad that the stresses of their work, eventually stopped them fighting for changes, because they were *just too tired*, which for me was a terrible irony.

Mel

Well, it's sad, very sad. Nobody in [primary care], and I can probably speak for everybody, nobody has any respect for [the specific hospital trust] at all. As an

organisation, they said they would treat us well, you know, they met with us when we were coming over from [the specific primary care trust], “we will look after you, we won’t make major changes, blah, blah, blah, blah, blah”, everything they’ve said, they went back on, every single thing, oh, it’ll be a completely different ballgame. (Mel: senior nurse: primary care)

Me: It sounds like there’s been a lot of changes in a short time. How does it make you feel?

Mel: Well, I am obviously not happy, and I’d say very apprehensive. There’s already been so much upheaval. I just hope the CCG’s and GP’s put their foot down and make them look after us [Pause] So much damage has been done. Staff, good staff have left. They just can’t seem to leave people alone and I really don’t know what will come of it all. No, I’m not seeing a whole lot of good come out of it. (Mel: senior nurse: primary care)

Mel spoke about the integration from a primary care trust into a large hospital trust. She reflected upon the hollow promises made to staff, which did not occur. Her intonation and non-verbal language communicated the anger she felt at the ongoing situation. She demonstrated her lack of trust and disrespect for the new organisation by saying ‘*blah, blah, blah, blah, blah*’, inferring their words were merely empty rhetoric and had no substance. She did not directly mention the blame culture as her issue was the lack of trust. Her view of the future service provision under the new leadership was initially articulated as one of sadness and insecurity, with her opening phrase ‘*it’s sad, very sad*’, and her closing phrase ‘*it’ll be a completely different ballgame*’. She demonstrated her desire to feel safe with the new organisation and initial optimism at the move, saying, ‘*they said they would treat us well, and “we will look after you”*’. However, then she observed ‘*on everything they’ve said, they went back on, every single thing*’ inferring that they have not looked after the staff or kept their promises. When I asked her directly how the changes made her personally feel, she was very quick to say that she was unhappy, then added her feelings of apprehension. Mel’s terminology was representative of Heidegger’s (1927/2010) *the-they*, and Mel appeared helpless to influence the changes and certainly seemed uninvolved with the redesign.

Overall, the texts signposted me to consider there was an existing blame culture, which appears to attribute blame and, therefore, makes individuals accountable for their actions and omissions. Participants articulated that the process made them feel that they were being punished for their actions. None of the accounts led me to believe there was in any sense a learning aspect to this method of investigation and treatment, so it is possible the same mistakes could reoccur. Marie, spoke about the '*long-hours culture*', of excessive workload and her inability to rectify the situation. The existence of a negative culture has been reported in several government investigations, and has been conceived as the central force that stops individuals raising concerns and makes them become desensitised to poor conditions (Berwick, 2013; Francis, 2013; Kirkup, 2015). However, Marie's text made me wonder if desensitivity derives from having to accept the situation because you cannot change it. Indeed, Mel's text was also supportive of her inability to change the environment, as she spoke of the broken promises and feeling unvalued by the organisation with what she saw as manager's empty rhetoric. Feeling unvalued was an issue also conveyed through Adam's text, and was expressed through Caroline's experiences. By using the hermeneutic circle, I became aware that the apparent culture was not merely about the concept of blame, as I had initially thought; it was about nurses' powerlessness to exert change, and the lack of caring leadership to nurture its staff. This led me to look at things differently, in a more holistic way. The whole, in this context, is the nursing profession whose voice seems silent about the culture that engulfs it. Participants displayed emotions of anger and frustration yet acknowledged the powerlessness they felt.

The observations made by participants seem reflective of Heidegger's (1927/2010) notion of how individuals cope with *being-in-the-world*, and the importance of culture. Heidegger (1927/2010) believes that culture and tradition could mask our pathway to *authenticity*, and be a hindrance to our understanding of *Dasein*. In uncovering these meanings, which can be masked in the taken for granted everyday, we can find new insights and perspectives, aiding self-understanding and affording a fusion of horizons. In exploring the culture of nursing, our pre-ontological understanding of *being* can be revealed (Heidegger, 1927/2010). Furthermore, *Dasein* fails to see its own possibilities when it is absorbed in its everyday mode of *being* in *inauthenticity*. Indeed, it is in this

mode of *being*, when it is constantly overlooked, that Heidegger (1927/2010) challenges us to uncover it, saying:

And because average everydayness constitutes the ontic immediacy of this being, it was and will be passed over again and again in the explication of *Dasein*. What is ontically nearest and familiar is ontologically the farthest, unrecognised and constantly overlooked in its ontological significance. (Heidegger, 1927//2010:44)

Heidegger (1927/2010) suggests that conforming to tradition in the everyday mode of *being* can be seen as a dimension of fallenness, as *Dasein* fails to recognise its possibilities. Heidegger (1927/2010) also asserts that *the-they* (*das Man*) is part of tradition and culture, which dominates and controls, preventing understanding of *Dasein* and *authenticity*.

The dominance of the public way in which things have been interpreted has already been decisive even for the possibilities of having a mood that is, for the basic way in which *Dasein* lets the world “matter” to it. The “they” prescribes one’s state-of-mind, and determines what and how one “sees”. (Heidegger, 1927/2010:222)

However, Heidegger (1927/2010) does not conclude with these thoughts, of *the-they* (*das Man*) being all powerful and controlling. Instead, he speculates on the prospect of individuals having choices, and in doing so adopting *authenticity* as a mode of *being*. Warnock (1970) observes that an *authentic* mode of existence can only be realised when an individual comes to understand themselves, as a unique being, with potential and possibilities to realise. Furthermore, Gadamer (1975/1996) embraces the value of historicity, culture and tradition, seeing it as something inseparable from our understanding and interpretation.

Culture operates at all levels of an organisation, and the effects of peer support must also permeate horizontally and transversely through all ranks and grades of staff. It is simplistic, yet common sense to say that kindness should be the operative word, but then a simple solution would be the most beneficial to all. The Francis report (2013)

also found that a pervasive culture of fear existed throughout the NHS and also in parts of the Department of Health. Mr Francis QC referred several times to the existence of bullying as the biggest component of the toxic culture he witnessed at the Mid Staffordshire hospital yet failed to make any recommendations to stop these behaviours (Kline, 2013). Since this study seeks to investigate the nurses' *lifeworld*, I now further explore the text to look for other perception's participants may have experienced pertaining to the culture of nursing in the NHS.

Essential Concept 2: The existential constitution of *the-there*

A mode of attunement: fear: the concept of fear in being-in-the-world in relation to the culture of the NHS

Introduction

This essential concept refers to the concept of fear in *being-in-the-world*, in relation to the culture of the NHS. I now explore the participants' observations and perceptions of how fear has been evident within their *lifeworld*. This essential concept that emerged from the data had a huge impact upon me. When listening to and reading the portrayal of emotion from within the text I was moved, not only by the participants' openness and vulnerability but also by the depth of feeling and 'rawness' it carried with it. I describe how the data has challenged my own preunderstandings, and influenced my present understandings, as I endeavour to interpret the text. I also look at the text through the hermeneutic lens, using Heidegger's (1927/2010) theories to understand how and why the participants felt and acted in the ways they did, observing how *Dasein* reveals itself through its modes of attunement, in this case the mood of fear.

Essential Concept 2

The text depicts the feelings of fear and anxiety which participants have experienced during their nursing careers, as students and as qualified nurses. The feelings of fear relate to various situations, from fear of making mistakes, to fear of new roles, to the fear of possible consequences from raising concerns. Fear can be a perception or a

reality for individuals and in both cases can present itself as a barrier to achieving *authenticity*. Fear can be debilitating yet can serve to protect the self from possible danger. Fear can be an instinct for survival yet can stop us from achieving our potential in life. In the following section, I uncover how fear has affected the participants in the study and explore its meaning, historicity and how it was dealt with by the individuals as they experienced it. With reference to the study's overarching aims, it explores the perceptions and insights of participants' experience in terms of their own professional and individual accountability, taking into consideration influences on patient care. It also draws on the previous section, which looked at the existence of a blame culture. The blame culture was observed by the Francis report (2013) and the Berwick review (2013) as being linked to a culture of fear in the NHS. It was therefore interesting that the issue of fear was evident through participants' texts and occurred at various stages within their nursing careers, as student nurses and as newly qualified staff, and also in role transitions. I therefore explore the possibility that the blame culture is linked to the concept of fear in the nurses' *lifeworld*.

The concept of fear is viewed by Heidegger (1927/2010) as being a mode of attunement. Heidegger (1927/2010) uses the term attunement to indicate ontologically what is most familiar to us; the way in which we interact with the world in one mood or another. Heidegger (1927/2010) does not wish the mode of attunement to become a study related to the science of our moods; instead, our mood is used to 'bring being to its there' (Heidegger 1927/2010:131). In looking at the mode of attunement we begin to see the revealing of *Dasein*, and our understanding achieves more clarity. Exploring the modes of attunement using a hermeneutical approach reveals why things matter and the part those moods play in the totality of the *lifeworld*, which incorporates the rich cultural and historical traditions. In short, by looking at our moods and emotions we engage in the phenomenological process of letting what is present reveal what is actually there.

The concept of fear emerged through the data on a number of occasions and in several contexts. The exemplars now presented portray the fear and anxiety the respondents have experienced in their role as a nurse or student nurse. This, above everything else I have encountered from within the text, has been the thing that has surprised and shocked me the most; an issue I shortly reflect upon when I am able to contextualise

my own feelings with those of the participants. In my personal reflection of my preunderstandings, I acknowledged that nurses' professional accountability was potentially compromised by their fear of raising concerns. This was a *fore-structure* present in my consciousness prior to the research, and although I had an expectation this would be present in the discourse, my intention was not to uncover what I already knew, but instead to look for new insight into the phenomenon. I did not, however, expect to be confronted by the depth of emotion attached to this concept, or indeed that it would impact my own preunderstanding, or to realise there is fear in so many other areas of *being* in the nurses' *lifeworld*. I am reminded of Heidegger's (1927/2010) definition of *aletheia* or 'truth', whereby he describes the search for the truth as like a torch being shone into the darkness, illuminating certain areas, yet leaving other areas in darkness. The truth that is referred to is not a correctness or absolute, it is an uncovering of something that was already there.

Marie

Marie is an experienced nurse who has been qualified for 35 years and had worked in primary care for the past 15 years as a senior nurse. When I asked her to tell me about her experiences of nursing she immediately referred back to when she had started her nurse training in the late 1970s. By doing this, I noted that she recalled the past then present events, moving back to the start of her nursing before returning to the present day, from part to whole and back again in a circular motion, echoing the hermeneutic circle. Her opening comment was quite a shock to me, as it was hard-hitting and abrupt and spoken with much assertion;

The culture when I started nursing was one of fear. (Marie: senior nurse: primary care)

She paused, which made the statement more poignant. Repeating the word fear, both to allow herself to reflect on her own words and to reiterate its importance:

Yes it was fear. We all felt it. We were frightened of the ward sister. We were frightened of being late; we were frightened of having a hair fall out of place; we were frightened and had a fear of things "that shouldn't be", like if the bed

cradles were under the bed or on the floor; you know, flowers being properly arranged and not dying in the vases. I think the patients were frightened as well of the doctors and the ward sister because I think it was, certainly in [location] where I trained, it was very strict, and everything was done for cleanliness and efficiency, and patients did what they were told to do and we junior staff, certainly student nurses, did what we were told to do. (Marie: senior nurse: primary care)

Marie used the term fear and frightened multiple times, and her non-verbal body language portrayed her annoyance as she spoke. Her voice was firm and assertive inferring feelings of anger, frustration and hurt. Marie used these experiences as a starting point to her story, setting the scene and informing me of her development in becoming a nurse. It is important to acknowledge our own history, and how our historical consciousness impacts our lives and understanding. It is through this historical awareness that Gadamer (1975/1996) believed that our understanding was informed. Marie was relating her everyday experiences of *being-in-the-world* from almost four decades ago, yet her emotions of anger and frustration, and possibly regret, were still very vivid in her facial expression and vocabulary. I suspect that she had not talked about these experiences in quite some time. She described the world as she encountered it at the time. She was a student nurse with no previous experience of the routine, culture and historical practices that were evident in the hospital. The description of the hospital environment is rich in detail, creating a picture through her recollection of the rules of “*things that shouldn’t be*” like...*bed cradles...under the bed or on the floor..., flowers...not dying in vases’* and of punctuality and a smart appearance.

Gadamer (1975/1996) reminds us that it is through language we engage and begin to understand our own *being-in-the-world*. It is therefore through Marie’s words that we can start to grasp an appreciation of what it meant to *be-in-the-world* of the student nurse in the late 1970s and early 1980s. Marie’s description reminds me of Heidegger’s (1927/2010) thoughts on how we interact with the world, being *ready-to-hand* (*Zuhanden*), *unready-to-hand* (*Unzuhanden*) and *present-at-hand* (*Vorhanden*). Heidegger’s (1927/2010) practical example of *Zuhanden* or *ready-to-hand* depicts a carpenter using a hammer, which in an experienced and skilled hand is like an

extension of his own hand; a transparent coping, where the carpenter is hardly aware of the hammer. He is able to talk or think about other things unconnected with the action of hammering. Each time he reaches for his tool, he demonstrates a *priori* perception, created through the experience of his craft. The relationship with the tool and the action demonstrates the *Zuhanden*, the way in which we generally engage with the world. *Vorhanden* occurs when we stop hammering and start to think about the properties of the hammer and study its structure. When something changes or goes wrong or we are presented with a new experience, we have to change our coping mechanism, demonstrating *Unzuhanden*, which is when we have to problem solve and rethink how to cope.

In Marie's text she described some of the 'rules' present in the new *lifeworld* of being a student nurse in this era. The rules such as not leaving the bed cradle on the floor under the bed were new concepts to her, not encountered prior to coming into nursing and so she was coping in an *Unzuhandenheit* or unreadiness-to-hand manner. We can also see that the items she mentioned are being engaged with using *Vorhanden* (*present-at-hand*) coping, which means she was seeing them as separate entities, aware of their structure and usage. When Marie talked about her recent nursing experiences, she did not draw us to focus on equipment or even environment. Her experience equips her with *priori* perception, and she had become adept at dealing with all manner of nursing equipment, situations and rules, allowing her to cope in a more transparent way for most of the time. Her *Umwelt* or immediate environment was unfamiliar and needed constant investigation and understanding as a new student, yet later in her career it becomes part of her everyday and entities become almost invisible. By utilising Heidegger's (1927/2010) philosophy, we can see Marie's situation and the ways in which she copes and interacts with the world differently. It highlights ways in which she could have been supported, through advice, mentoring or reflective practice, which I explore after Jean's text has been presented

Jean

Jean talked about her student nurse training from a different perspective. She made the following comments:

Well, I went into nursing later in life, I was 21 and had worked in a hospice; I was older; I was married. My experience was very different. I had respect. I wasn't living in. I think the staff I worked with were better with me. I had a good experience. It was a different world then though. The other girls on my course had a very different experience. In theatre I went to the small plastics theatre with three other girls and had a great time, they loved us. The other girls went to main theatre and had a wicked time. They were shouted at, told to get things, stood in a corner, sometimes no one would speak to them. They hated every minute, and it was awful for them, but that was the way it was. (Jean: multiple roles)

Jean observed how her experiences were very different from her peers, a situation which she attributed to her maturity, status and attitudes. She noted that her peers suffered uncomfortable and possibly degrading treatment but that she was treated very differently. She demonstrated her compassion for them, seeing it as *'awful' and 'wicked'*, but also she had an acceptance for the situation in her observation *'that was the way it was'* and *'It was a different world then though'*. Jean's comments reinforced the historicity of nursing. Although Jean did not express that she felt fear or anxiety during her nurse training, she acknowledged it was possibly present for her peers as they were *'shouted at, told to get things, stood in a corner, sometimes no one would speak to them'*. It would seem that the anxiety she noted that was present for others was fear of specific people's behaviours, and fear of making mistakes. She observed that *'They hated every minute'*. Jean and Marie's texts were steeped in history and tradition, and before I elaborate further, I remind myself of Gadamer's (1975/1996) words that I may never achieve a correct interpretation, but I may achieve an understanding based on my own changing horizons (Gadamer, 1975/1996). Gadamer (1975/1996) speaks about the linguistic tradition, which enables information about historical practices and traditions to be 'handed down' utilising the interpreter's own background knowledge. Gadamer's (1975/1996) words settle with me here, as I relate to similar memories from my own student nurse days when I was shouted at and humiliated during my theatre placement. Jean's text could be almost an observation of me and my peers in our experiences of that theatre placement, as the story she related involves similar scenarios to my own; a memory I discuss shortly.

In Marie's account of her student nurse training, we are able to glimpse into a period in history and gain some insights into how she thought and felt in *being-in-the-world* then, keeping alive a bit of history. The concept of time is a central tenet to Heidegger's (1927/2010) work, which asserts that time is how we connect with the world in relation to measured time. He observes that temporality incorporates the three interrelated perspectives of our past, present and future. Using the hermeneutic circle, we can incorporate these perspectives, aware that our *Dasein* is always in the present but based on our past experiences and future projections. In Marie's text she looked back upon the experiences of her *being-in-the-world* as a student, which was to influence her future life and career. Of course, when looking at her experiences of that time, they were also affected by her past prior to her nurse training, her upbringing, her culture, her education and her *fore-understandings*, but also, she was viewing them through the lens of her present. From the text we see Marie depicting the memory of fear that surrounded the new cultural norms of her *lifeworld*, yet there was no mention of her not conforming to the rules. By conforming to the rules, she loses her *authenticity*, in the Heideggerian sense, and takes on an *inauthentic* mode in order to 'fit in', despite the fear and display of powerlessness: '*patients did what they were told to do and we junior staff, certainly student nurses, did what we were told to do*'. She then went on to give a justification for the rules of '*cleanliness and efficiency*', which she later extols as almost forgotten values within the modern healthcare setting.

The way in which Marie had experienced nursing in her early career will have had a great impact upon her later choices and actions. Heidegger (1927/2010) brought this aspect of learning and understanding from our past, present and future to remind us of the temporary existence we have on Earth. *Temporality*, the term he refers to, to represent our journey from birth to death, is an important concept, and is closely linked to the idea of *spatiality*, as existence is not only *temporal* but *spatial* in nature too. Heidegger (1927/2010) states that our past, present and future are conjoined in a unique and complex way, with each influencing the other and so creating the phenomenon of *temporality*. He adds to this, by noting that in order to reach true *authenticity* and truly understand the concept of *temporality* we must think intently about our own death and mortality.

It was important to look at Marie's text, using the hermeneutic circle, combining my own preunderstandings and *fore-structure* to promote an understanding by embracing the idea that understanding can develop and grow through looking at the whole and constituent parts, and vice versa. Sandelowski (1993) advocates that researchers should portray their own feelings concerning interviews, to add credibility to the study. As a nurse myself, I can relate to Marie's words and feelings, although when carrying out the interview I felt shocked at the emotion and content of her words. Following this interview, I felt bombarded by memories of my own nurse training and the emotions this period of my life held. These were not recollections I often thought about and not within the context of fear and anger, which Marie had displayed in her interview. I realised, however, that I had felt frightened of making mistakes, of being late and of failing. I thought about some of the powerful leaders on wards that I had worked on and the historical practice that Marie had described, and Jean recounted from the perspective of being an observer. Following Jean's interview, I reflected upon a couple of very traumatic episodes I had experienced whilst on my theatre placement. The first was an incident to do with raising concerns, discussed in Chapter 4 and the second with the fear of specific members of staff and the unfamiliar environment I found myself in. The experience was very similar to that described by Jean from the standpoint of a spectator. This extract is taken from my reflective journal, which I kept during this study;

Whilst halfway through my eight-week theatre placement as a second-year student nurse, I was told to stand next to the experienced scrub nurse. The surgeon was mid-way through a surgical operation and asked to be passed a specific surgical tool. Although very apprehensive, I assumed I was being spoken to and passed what I thought was being requested, off a tray within my reach. Suddenly the surgical tray, covered with green surgical cloth was bodily thrown at me, landing with a crash at my feet. The surgeon shouted that I had contaminated the entire sterile field, and that I had to run to the sterilising unit to get a new "ortho pack". I was stunned, frightened and found it difficult to comprehend the instruction, but hurriedly picked up the tray of instruments and ran out of the theatre, as fast as I could. I got to the sterilising unit, which was governed by a man who himself frightened me, and asked him for the "ortho pack", giving him the one in my hands. He then shouted at me for not following

protocol and bringing dirty instruments into the clean area, before giving me a replacement pack. I hurried back to the theatre to find them all laughing. I can still remember the humiliation and trying not to cry in front of them all. What I couldn't fathom out then, and still can't now, is why they all seemed to enjoy being so mean.

This incident was not an unusual event at the time, and reminiscent of Jean's observation '*but that was the way it was*'. My experiences during my theatre placement were decidedly the worst of my nurse training, and I would say, retrospectively that fear dominated the whole eight-week placement. The fear was of specific members of staff, of the unpredictability of the situation and the unfamiliarity of the *Unzuhandenheit* or *unreadiness-at-hand* environment. These were disturbing aspects of my student nurse training, and I would assume these same situations would still be distressing for contemporary nursing students. The thought that '*the way it was*' was a culture of humiliation and fear was a distressing memory to recall and leads me to ponder why I was so shocked on hearing Marie comment on the '*culture of fear*'. I think I felt shocked because she had managed to articulate the feeling. She had named the mood. Had someone asked me about my training, I would not have used the word fear to describe it, and perhaps by calling it fear, makes me question why I chose to accept the situation that was clearly unacceptable, but as Jean observes, that was '*the way it was*'. By viewing fear as a mode of attunement, my own feelings had been unveiled to me and had allowed me to get closer to my own *Dasein*. The idea of *temporality*, and the fact that these experiences formed part of the participants' past, and similarly mine, focused my thinking on how these experiences had influenced our careers and the ways we had behaved. I was certainly constructively influenced by the positive role models from my student nurse training, and still remember fondly those kind and compassionate staff who I aspired to model myself upon.

Heidegger (1927/2010) describes fear as always fear of something. The analogy used is of a person being afraid of spiders, showing that the person who is afraid of spiders only feels afraid when they see a spider, and when the spider is taken away the fear subsides. However, Heidegger (1927/2010) comments that anxiety can be about everything, about *being-in-the-world*, and can be all consuming. Marie described the culture of nursing, contextually, as one of fear. She described her fear of making

mistakes, of the unfamiliar environment, and her fear of the individual ward managers. I think it would be wrong to suggest that all nurses feel frightened the majority of the time, but it seems fear is apparent in individual areas, such as raising concerns and making mistakes, and of specific people. With this new understanding I have gained, I look back at the text in relation to the whole, and now see things a lot more clearly. Marie is in her early sixties and continued to nurse. She has had an accomplished career, both in nursing and in industry. On interviewing Marie, I found her to be a very warm and caring person, particularly when referring to colleagues and nursing friends. My interpretation of the text leads me to suppose that her early career, of which she spoke in the interview, has influenced her behaviour and her career in a variety of ways, such as the way she interacts with others and nurtures more junior staff. It also leads me to wonder why such negative experiences have had such positive effects on her life, as it could equally have resulted in her mirroring such negative role models. Reflecting upon this, I realise that she used these experiences very productively, to selectively mould her personality and career, learning from others actions and approaches.

Gadamer (1975/1996) speaks about the fusion of horizons, when the interpreter searches for meaning and understanding in the text, and how if the interpreter enters into the hermeneutic circle, aware of their own *fore-structures* and preunderstandings, new understandings can emerge. I am also reminded of Heidegger's (1927/2010) thoughts on interpretation and understanding, which observes that the process is a reciprocal one, and that I am learning about my own *being* in learning about the participants' *being-in-the-world*. Gadamer (1975/1996) adds to this by suggesting that as well as the interpreter's dialogue with the participant, there is also the process of speaking to one's inner self, which he refers to as *I-lessness*. When noting my own preunderstanding, I did consciously acknowledge there was a culture of fear surrounding whistleblowing, but I did not anticipate the idea that there was fear around specific things such as making mistakes, of making errors in judgements or of fearing individuals. This is not to say that I did not believe the presence of fear existed, but I had not defined it so specifically before. I had also not acknowledged that I had been fearful of these things in my own training, although perhaps I had not named the emotion I had experienced as fear.

Caroline

Some 40 years had passed since Marie's experience of student nurse training, and 30 years since my own, so I felt rather sad when interviewing Caroline, who had only recently completed her nurse training, that placements could still be difficult. Perhaps I was being somewhat naive to consider nurse training had become easier, but in fact she had still been confronted by staff who made placements uncomfortable. These were her comments:

I enjoyed most of my training, but there was one ward which was awful, because the staff were really cliquey. I didn't feel like I could trust anyone. I don't think they should have been allowed to have students. At the end of the day you have to pass the placement, so it doesn't do to make waves. I didn't even say much in the evaluation in case it got back to them. I was the only student on that ward, so they would have known it was me if I said something negative. Everyone knows where the bad wards are. (Caroline: newly qualified staff nurse)

Caroline did not directly refer to her bad experience on the ward as fear, but none the less it was very unpleasant and upsetting, leading her to feel that the ward should not be allowed to have students, which is a very strong negative reaction. Reflecting on this interview, I felt that what she was describing was fear. I could relate to this as I had felt the same during my own nurse training, and it seemed that the need to pass the placement remained paramount, despite three decades separating the experiences. There was also a sense of reporting things being a futile exercise when she said that '*everyone knows where the bad wards are*'. Caroline's comments were also reflected in the literature. A mixed method study by Stevens et al (2014) found that the situation for students continues to remain problematic when confronting qualified staff who act as variable role models as the students want both to 'fit in' and conform to placement culture, balanced with the need to pass their clinical placement whilst also finding an emotional safety for their learning. The study went on to report that students experienced feelings of being unvalued and fearing retribution from questioning practice. Reflecting again on Caroline's text, it is clear that the ward in question did not afford her a safe environment, as she observes that in the situation 'I

didn't feel like I could trust anyone'. Heidegger (1927/2010) refers to this safe haven using the notion of *dwelling*, observing,

Dwelling is not primarily inhabiting but taking care of and creating that space within which something comes into its own and flourishes. (Heidegger, 1954/1993:362)

Heidegger's (1927/2010) conceptualisation of *dwelling* relates to *Dasein's being-in-the-world*. *Dwelling* in this context is much more than physical shelter, but a place that can offer safety, peace and allow individuals to be nurtured and encouraged to develop. In the situation being explored in the text, the sense of safe space had been broken, and Caroline's sense of wellbeing was being threatened. These perceived tensions across the contexts of education and practice could lead to 'value dissonance' and emotional distress, according to Lipscomb and Snelling (2010).

Dawn

Fear in nursing does not appear to be unique to pre-registration nurses, and in another transcript, Dawn spoke about her experience of fear in *being-in-the-world* as a post-registration nurse, and the similar challenges that were apparent.

You get institutionalised. You are afraid to speak up. In [location] we had a horrible manager. She was totally unpredictable. We were all frightened of her. Completely horrible. You wouldn't know what would happen. When I left, the others all went to the manager and said you must remove her or none of us will go to work today. I wasn't there. It took many years of being unhappy. It broke many people. Some people say you have to go through it to make you stronger. We shouldn't allow this to happen. (Dawn: senior nurse: acute care)

Dawn spoke of her fear of a specific manager, and the powerlessness she felt when difficulties were occurring. Instead of confronting the situation, Dawn chose to leave the environment as her way of addressing the issue. She related how her colleagues that remained eventually dealt with this individual manager, and the pain she observed. The behaviour that made Dawn feel fearful seemed to have been related to

the unpredictability of the specific manager. The feeling of fear was shared by all those working there, and perhaps the shared emotion gave them a greater sense of camaraderie. There was a sense of sadness and anger in Dawn's text, when she commented: *'It broke many people. Some people say you have to go through it to make you stronger. We shouldn't allow this to happen'*. The last phrase *'We shouldn't allow this to happen'* seemed to be Dawn's plea to all nurses, viewing fear as an emotion that should not exist in nursing. She conceptualised the group's behaviour in accepting the situation as becoming *'institutionalised'*, which denotes that fear was taken as a social norm within that environment, and that everyone working there conformed to the established conventions in place without questioning them, or indeed questioned them but felt powerless to change them. Dawn's text again conveyed the *inauthentic* being in Heideggerian terms, and how *the-they* controlled the culture, suggesting that fear had become a barrier to their *authenticity*.

The text related by Dawn was very poignant and from a personal perspective quite distressing. Walsh (1996) discusses the emotional connectedness that can be felt by the researcher when they relate to the text and have a shared experience of a situation. Following Dawn's interview, I reflected upon a situation I had experienced within my own nursing career whereby a senior manager dominated the working environment with fear. I recalled a similar feeling of powerlessness to change the situation, as no other staff member would support me in confronting the specific member of staff. As in Dawn's case, I opted to leave the role to prevent further stress to myself. Dawn's thoughts echoed my own feelings of distress and of hermeneutic understanding of shared understanding. I related to Dawn's anger in not preventing the situation for others. Returning to reflect upon Walsh's (1996) comments, the text allowed me the emotional connection to see how fear had prevented my own *authenticity* to confront *the-they*. Dawn's historicity and environment was very different to mine, and not comparable, but the feelings we both experienced allowed for a new understanding to emerge. Dawn also reflected upon the notion that those painful experiences make one stronger but concluded that they were not a necessity in character building. Looking at the text as a whole with this added understanding, it shows how the experience had a profound influence upon Dawn, and later articulates this:

Dawn

We as nurses need to make more decisions, we need to take control. Our nursing bodies need to make more decisions. Be more visible. I think that nurses should stand up for themselves. (Dawn: senior nurse: acute care)

Dawn's later comments show how she used the negative experience in her past to make her stronger, more assertive and successful in her career. Her future aspirations for the nursing profession are for a more visible and audible body, which is unafraid and united. She clearly reflected upon her past experiences to allow her to become *authentic* and make decisions to fulfil her potential, and now believes in the potential for the nursing profession. One of her personal decisions was to leave her country of birth and move to the UK to enhance her nursing career. She demonstrated how in Heideggerian terms she has embraced her potentiality and *Dasein's being* and actualised its own possibilities. Dawn also showed her understanding of the effects that others have had on her behaviour, in *being-with (Mitsein)* as she moved into *authenticity*.

Mel

Mel spoke about the fear of taking on a new leadership role; like Marie, it related to the way in which she interacted with the world in an *Unzuhanden* manner, where her role, her *Umwelt* and her colleagues were all new and unfamiliar. This initial fear seemed to be fear of the unknown, of failing or of making mistakes, as she moved into a role where her team, other healthcare professionals and patients on her caseload, were depending upon her to make decisions and to lead them. She initially felt unprepared for that but was motivated by the collegial support. These were her comments:

After I'd done the course [post-registered training] I went straight on to a G grade [senior sister]. I remember I was given a practice in [location]. I remember thinking "What have I done, this is scary, this is really scary". I suddenly had my own team, and I was like "Oh my God". At first, I was so scared, but I got to grips with it, I really liked it and I've

always enjoyed the leadership side of it and the hands on but mainly the leadership. So I had a team of nurses, erm, [pause] who were with me. [Pause]. There was another practice there with another [primary care service] sister who was also a [primary care service] practice teacher. I can say this as it's all part of my story, but she absolutely did my head in; she was very lazy, and she'd been there a long time, and all her team waited till she was off to ask me questions. I had to sort out all her patients as well! So I was really busy but it was really worthwhile as I was seeing, erm, patients being managed well, due to my hard work and leadership. I also then, had the opportunity to do the nurse prescribing. (Mel: senior nurse: primary care)

Mel described the change in her role from a junior staff nurse to holding a senior sister's post in primary care. She asked herself '*What have I done?*' as she felt frightened of the fact that she was put into the position of leading a team of staff. She attributed her success in the role as being due to her '*hard work and leadership*', but also to the support from colleagues when she said, '*they were with me*'. She also mentioned the senior sister from the adjoining team with whom she felt a sense of frustration; in her words '*she absolutely did my head in*'. There was no mention that this created a confrontational atmosphere, as it seemed that staff waited until the other sister was absent before getting Mel's assistance. As a new member of staff and newly appointed manager, this area of potential conflict would have been difficult to navigate. Mel chose not to directly confront the person involved, instead using her absence as a means to manage the situation. Since she did not mention any subsequent conflict, it can be probably be assumed that this process of problem solving was successful, although at a cost to her. Despite her initial fear, which could be interpreted as *Unzuhanden* coping, she felt that the experience was '*worthwhile*' and satisfying, as she could see that patients were '*being managed well*'. Mel described her own professional development in similar terms to Benner's (1985) study which depicts the transition *from novice to expert*, moving from *Unzuhanden* to *Zuhanden* coping.

Caroline

Caroline, a newly qualified nurse, shared similar feelings of insecurity and anxiety, as she articulated her transition from a student to registered nurse. Like Mel, she was

frightened at the responsibility of her new status, and of the autonomy she experienced.

Being qualified isn't really what I expected if I am honest. I've spent three years wanting to be here, wishing my time away. Now I am here, it's like [pause] well it's good knowing you have got that status, but then you haven't got that sense of being protected by the University, and you haven't got all your friends around you. You feel like you're on your own. Like I was visiting this lady in her home after she'd had an operation and I took the dressing off and the wound just kept on bleeding and wouldn't stop. In the end I decided to ring the sister for help. She just came over and when she couldn't stop it we rang for an ambulance. The point is I was on my own. I was worried that I had done something wrong, or it was down to me being newly qualified. The responsibility in [a specific primary care service] is huge, and I am not sure I was properly prepared for it. When you're shadowing other nurses, you feel all calm and confident. When you're on your own it's very different. You can question your own abilities.
(Caroline: newly qualified staff nurse)

Caroline's text allows us to visualise the anxiety of being an autonomous practitioner in primary care, where making independent decisions can be overwhelming. She questioned her own competence and knowledge, in the first instance by saying, '*I was worried that I had done something wrong, or it was down to me being newly qualified*', and in the second instance, '*You can question your own abilities*'. This seems again reflective of *Unzuhanden* coping and may have been lessened by a lengthier period of shadowing qualified staff. The text, however, was also suggestive of Caroline demonstrating a fear of making mistakes. Using the hermeneutic circle adds further depth to her text, moving from her experience of managing a clinical issue to viewing the wider blame culture she was exposed to. Reflecting back on Caroline's experience of seeing nurses being held accountable and receiving punitive sanctions appears to have affected her confidence. Additionally, she had only recently acquired professional accountability through her registration, and this presents a new concept for her to understand and internalise, perhaps intensifying her fear of making mistakes. Returning to the Hermeneutic circle, my own understanding has changed as I consider how the whole had effected the parts, and vice versa.

This essential concept of fear as a mode of attunement has demonstrated that the participants, and indeed myself, have felt fear in *being-in-the-world* of the nurse. I would conceive that at times, fear was masked by anxiety as well as anxiety being heightened because of fear, emotions commonly experienced in the *Umwelt*, when the environment is unfamiliar. The coping observed was *Unzuhanden*, without fluidity and was often manifested by fear. In nursing, this *Unzuhanden* coping will be apparent in nurse training, in qualification to staff nurse, in role transitions and in rotational situations. Heidegger (1927/2010) uses the term *dwelling* to refer to the search for a place of emotional or psychological safety, often associated with a home. This is not a literal or physical building, more a mental state where peace and contentment can be found.

The concept of fear was also apparent in participants' earlier texts with regard to the fear of making mistakes, a situation no doubt compounded by the existence of a blame culture. However, fear may not be the only issue apparent in raising concerns, as Marie testified to in her experience of the futility in the reporting systems in place, which did not bring about change. In the next short section, I reflect upon how two participants, Gemma and Adam, adopt a self-protective mode of behaviour to explain why they would not raise their concerns in the practice environment.

Essential Concept 3: Self-preservation within the culture of the NHS

Introduction

Whilst looking at the essential concept of fear, there was also the issue of how individuals dealt with it. For two of the participants, Adam and Gemma, their coping mechanism was that of self-protection. Of course, their comments could have been incorporated into the previous section on fear, as there is a commonality present. However, the nuance that was uncovered was reflective of Heidegger's (1927/2010) assessment of *authenticity*. On the one hand self-preservation acts as a barrier to *authenticity*, by preventing our realisation of potentiality, yet it could also involve a confrontation and deliberation of risk. Self-preservation is not a concept captured in

Heideggerian philosophy, yet it is a phenomenon that encompasses *the-they* and *they-self*, *authenticity* and *inauthenticity*, and also *the call of conscience*. This phenomenon appears to explore the participants' experience of their own individual and professional accountability, yet also their need for a safe *dwelling* place, within their *lifeworld*. The following analysis explores this essential concept in more depth.

Essential Concept 3

Self-preservation can be observed as an *inauthentic* mode of *being* in relation to professional accountability as it provides the self with its own security, but can be influenced by *Dasein's call to itself*. Heidegger (1927/2010) reminds us that *Dasein* in its essence is developed by the choices that are made and always has *potentiality* or *possibilities-to-be* (Heidegger, 1927/2010). Self-preservation can be interpreted as being directly linked to the mode of attunement of fear, yet is its own essential concept. In the following vignette from Adam's interview a different mode of *being* could be seen in relation to his professional accountability and whistleblowing. It can be observed that he made a conscious decision to choose not to adopt *authenticity* and confront *the-they*, as he showed an insight into the possibilities that could ensue.

Adam

Adam is a nurse in his thirties who holds a senior nursing role in an acute care setting. Following on from his thoughts about the culture on the NHS I asked Adam if he felt he could use the whistleblowing policy if he found himself in a situation that required it. He responded by saying:

I could use the whistleblowing policy but I would not win. You can't touch the top people; [workplace name] is a powerful place. (Adam: senior nurse: acute care)

Me: *So you could use the whistleblowing policy, but you wouldn't win. Is that how you feel?*

Adam:

Yes, I wouldn't win. So I go with the flow. (Adam: senior nurse: acute care)

Me: Oh [Pause] But if something dangerous happened, like an incident, could you report it to someone?

Yes if something happened, there might be an investigation. I would tell them what had happened. I would never cover anything up. (Adam: senior nurse: acute care)

I initially found Adam's comments rather surprising, and my replies no doubt reveal that, as I struggled to make an immediate response. I felt quite shocked when he described the senior leaders as being so powerful, in his phrase '*You can't touch the top people*', almost inferring in some ways that they were above the law. I initially I felt that his response was motivated by a fear of raising concerns, in that he felt the people in authority were too powerful to confront. However, when I revisited his text using the hermeneutic circle my understanding changed, and I saw and heard Adam's sense of powerlessness at the situation. He was not, as I first thought, adopting the mode of attunement of fear; he was instead choosing a realistic option of acceptance when he said '*I wouldn't win*'. Adam used the word '*they*' to refer to those people who held the power in the organisation, and in this metaphorical context, the 'winners'. This terminology is again reminiscent of Heidegger's use of *the-they* (*das Man*). Heidegger's wrote:

We understand ourselves in an everyday way or, as we can formulate it terminologically, not authentically in the strict sense of the word, not with constancy from the most proper and most extreme possibilities of our own existence, but inauthentically, our self indeed but as we are not our own, as we have lost our self in things and humans while we exist in the everyday. (Heidegger, 1927/2010:160)

This attitude to our daily life demonstrates Heidegger's (1927/2010) theory of understanding ourselves, in our situation in life, and accepting the things that are happening without questioning our ability to make changes and choose a more

authentic way of *being*. It seems that the majority of people have this acceptance about life in general, and as Adam said, '*go with the flow*'. Adam's behaviour is one of acceptance, but not an acceptance without question. On the contrary, he has clearly considered the options, and decided that on balance he '*would not win*', and therefore would not pursue the fight, demonstrating *inauthenticity* as he conforms to *the-they*. Indeed, Heidegger (1927/2010) explains that as individuals we are inseparable from the world, a concept captured in the phrase *being-in-the-world*, and as such we have a constant interaction with the *the-they* world. Crotty (1998) observes that *the-they* (*das Man*) represents the social, cultural and organisational expectations we conform to, making our everyday lives meaningful and comprehensible. Heidegger (1927/2010) comments that this autonomic or subliminal conformity to these expectations can lead us to a self that is *inauthentic*; a *they-self* that in turn causes us to be involved in trivial aspects of living, as opposed to thinking about our real potential. Adam, however, has given thought to the potential aspects of his behaviour. I am reminded also that an *inauthentic* way of *being* is neither a positive nor a negative state and is neither moral nor immoral. Indeed, Heidegger (1927/2010) articulates that it is a mode of *being* that serves to protect ourselves from the *existential angst*. The word *angst* is generally translated to anxiety in the context of Heidegger's (1927/2010) writings. Returning to the text, Adam had therefore protected himself by his *inauthenticity*, and was able to exist in the everyday as the majority of individuals do.

Gemma

Gemma's text portrayed a similar method of coping. However, in Gemma's case she had a *priori* experience of whistleblowing that had informed her decision making.

There was a time when the workload became just too great. I involved the union because I complained that we had no time to manage. That the workload was too great. But then the management got HR in and said that I wasn't managing. It became a punishment, and I felt penalised. It was a terrible time. I didn't lose my job, but I wouldn't do it again. (Gemma: staff nurse: acute care)

Gemma related a past situation when she raised concerns over the workload, as she felt that it was an unsafe environment. The outcome, however, saw her being

performance managed, which she felt could have had the potential for a disciplinary action against her. The experience left Gemma feeling the personal cost was very high, and that she would not repeat this strategy. The *angst* that Heidegger (1927/2010) refers to when confronting *the-they* (*das Man*) and taking on an *authentic* mode of *being* was clearly visible in Gemma's experience. By adding '*I wouldn't do it again*', she displayed her self-protective instinct. Gemma had made a decision not to repeat her previous actions, demonstrating an *inauthentic* mode of *being*.

Undertaking this work has led me to reflect on my initial thinking and preunderstandings relating to raising concerns. '*Professional accountability can be compromised by nurses feeling too frightened to raise concerns as they fear the consequences of such action*'. I now see a different perspective, developed through the constant back and forth reflective process, reflecting on and revising my own position as the work unfolds. I am now able to see how Adam and Gemma were resigned to the situation, viewing it as the *everyday*. *I now see the self-protective mechanism in play of the inauthentic mode of being*. Self-preservation is not just a primal instinct to survive; it is a complex notion of human responsiveness to existential factors (Lysemose, 2013). This follows the anthropological theory of responsiveness suggesting that the *being* in human being is 'becoming human' (Lysemose, 2013). The mode of this 'becoming human' is that of self-preservation. In the process of becoming human, which will inevitably involve success and failure, we preserve balance (Lysemose, 2013). With this in mind, I now relook at Adam and Gemma's texts as one of self-care, of preserving the balance in his/her self, his/her *being*.

From a personal perspective, I was reminded of the incident in my student nurse training I reflected upon earlier regarding raising concerns about the anaesthetist in Chapter 4. For many years I have conceived this to be an injustice, and that my complaint was mismanaged, leading me to think that I was being silenced. However, through this research process and my analysis of the text using the hermeneutic circle, I now have a new perspective on the incident. On reflection, I see this as me being protected by my tutor against much distress and angst, which in fact enabled me to have a safe *dwelling* place for my learning. Riceour (1978) sees this reflexive process as one of self-discovery, through becoming engaged with the text. Gadamer (1975/1996) declares this new found understanding as a fusion of horizons, whereby

the researcher's interpretation is fused with their own historicity and experience to produce new understandings.

The call of Dasein to itself

Adam's text denoted his honesty and moral values, saying that he would be truthful and never cover anything up. He disclosed that he would co-operate, but not initiate, an investigation, again reminiscent of the self-protective response discussed previously. Adam made me aware in the discourse that he had a sense of right and wrong. Heidegger (1927/2010) describes this ethical positioning as the 'call of conscience', which could be thought of as revealing *Dasein's authentic being*:

Thus conscience reveals itself as an attestation belonging to the being of Dasein, an attestation in which conscience calls Dasein forth to its own most potentiality-of-being. (Heidegger, 1927/2010:288)

The call of conscience silences *the-they* of the world and reminds us of our *authenticity*. Conscience is a call that silences *the-they* in the world and allows *Dasein* to look at itself, and its *potential-to be*. Heidegger (1927/2010) advises that the call of conscience means we are called to make choices, and we have a choice whether or not to make that choice. In the biblical use of the term conscience, it is the voice of God calling to man. In Heidegger's (1927/2010) view, the call is a silent call from our own *Dasein*, calling to itself, pulling us back from the *inauthenticity* of our everyday life. It is interesting that the call is silent, and the silent voice of *Dasein* in turn silences the 'noise' of the world. By hearing and understanding the call of conscience we adopt an *authentic* mode of *being*. Heidegger (1927/2010) observes that *Dasein* does not give itself guilt, as guilt means to be in debt to the world. *Dasein* is already in debt by its very existence and, therefore, is guilty but only recognises its guilt by understanding the call of conscience. When this understanding occurs, *Dasein* becomes *authentic*, which Heidegger (1927/2010:288) calls, 'wanting to have a conscience' (*Gewissen-haben-wollen*). Through this process of self-understanding, of understanding the call and wanting to have a conscience, the individual becomes responsible and resolute. This is reminiscent of Aristotle's notion of the virtuous person whereby virtue reveals itself through action and is developed through upbringing and practising good habits,

with the virtuous person being able to see truly and judge rightly (Thames, 2005). This discussion around moral judgement and the decisions we make being seen in the context of our *being-in-the-world* is reflected in the literature on whistleblowing. A common point of reference is the dilemmas faced by staff who are entrenched within a situation and enveloped within the culture (Berwick, 2013; Francis, 2013).

Essential Concept 4: *Being-with (Mitsein)*: positive collegial relationships in *being-in-the-world* relating to the nurses' lifeworld

Introduction

This section presents data relating to the essential concept of *being-with (Mitsein)*, in respect of the positive collegial relationships *in being-in-the-world* relating to the nurses' *lifeworld*. This is intended to demonstrate the stratified nature of culture, in terms of the interpersonal relationships that form part of the whole. I explore how the participants have encountered positive collegial relationships, and the effects these have had upon them. I also share my own perspectives on this, and its overall value to the culture of the NHS. Taking the Heideggerian concept of *Mitsein* or *being-with* I look at how this relates to individuals and their interactions with others. This essential concept addresses the study's aims by looking at how nurses experience their individual and professional accountability.

Essential Concept 4

In nursing, our *being-with* other nurses, in an everyday sense, and of belonging to the 'body' of nursing in the broader context are important aspects of nursing. Collegiality is the broad term generally used to describe the relationship between colleagues in a specific profession, and identifies a positive interpersonal relationship (Padgett, 2013). Mahon and Nicotera (2011) assert that collegiality is generally accepted as the first line of professional self-regulation, although admit this can be a flawed process when nurses are reticent about confronting their peers. Collegiality is a multidimensional concept, which has been widely studied in both qualitative and quantitative research approaches (Hansen, 1995; Duddle and Boughton, 2007; Padgett, 2013). Collegiality

is a subject that was mentioned within the interviews and adds a positive perspective to the notion of *being-with*. Participants' experiences of positive collegial relationships are presented here.

Jean

Jean holds three part-time jobs in both the private and public sector and here she described working in a private healthcare setting five years ago:

When I was a full-time sister, we worked well together. We looked at patient need, business need, staff need. I always looked at numbers; I always looked at the bigger picture. I had a good bunch of staff. (Jean: multiple roles)

She went on to describe her role as a triage nurse in the NHS:

The support is excellent. They have lots of workshops, training, help with revalidation. They have put lots of workshops on for the revalidation. We all get on well which is half the battle. (Jean: multiple roles)

Then, working as a practice nurse in a GP surgery:

The support I have had and do have from the GP has been brilliant. I was on my own, no one to go to in my practice. I have a very good friend in the practice next door, who was always there for me, if I needed anything, if I wanted to ask anything, and in the practice we now have a [specific primary care role], part of the CCG, who keeps us aware of everything. I have been very lucky. (Jean: multiple roles)

Jean's text depicted the strength she received from her colleagues and peers. She had clearly benefitted in terms of her general emotional and physical wellbeing from such positive influences. It had also allowed her to professionally develop through academic assistance and afforded her a safe *dwelling* place. When engaged in discourse with Jean, her outlook was incredibly positive, and she showed a real sense of confidence and being in control. It can be noted from other exemplars that she

displayed an ability to bring an optimistic and positive stance to most subjects, denoting a transformational trait of leadership. The fact that she holds down three part-time jobs in nursing in diverse settings also leads me to think that she is quite a dynamic individual. This was also demonstrated in her text pertaining to her experience of being a full-time sister, where she acknowledged the need for awareness of the '*bigger picture*'.

Gemma

Gemma is a mature staff nurse, with 21 years' experience in both acute and primary care. Here she described her decision to return to the hospital after working in primary care for around 12 years.

For several reasons I decided to come back into hospital nursing and applied for this job in the hospital. I think I missed the structure of nursing in the hospital, and the camaraderie. I had to do a large presentation at the interview, so I felt quite lucky to get the job, after being out of the hospital environment. It has been a steep learning curve, as I am quite old, but I love it, and I am enjoying it. (Gemma: staff nurse: acute care)

Gemma's text showed how she had actively sought the collegiality of her peers, by moving from primary care, where she had a more autonomous role, to the hospital setting. She described the interview process and the transition back into the hospital environment, both of which would have been uncomfortable, and adopted *Unzuhanden* coping. However, she did so because she '*missed the structure of nursing in the hospital, and the camaraderie*'. Her final words show that her decision to change roles was merited as she declared her satisfaction with her new position.

Marie

Marie is a senior nurse and spoke of her recent experiences in a primary care setting, where she had worked for the last 15 years:

I think certainly in the last five years staffing has got worse. I've been quite shocked at just how low the staffing levels are getting and have really felt quite heart sorry for the teams, especially the full timers. I've seen how hard they work and how much pressure they are under and the extra hours that they put in that probably isn't paid or given back in time. If the staff didn't look after each other, there wouldn't be anyone left. I know staff look for other jobs cos it's just relentless, the pressure. (Marie: senior nurse: primary care)

She then talks about the reliance she had on other staff to assist her if anything went wrong in practice.

When you're really stretched I think on weekends and bank holidays you do feel nervous when you have a lot of [specific medical condition] patients and some end of life palliative care patients, who could ring at any time. You feel torn really. [Pause] Depending on who you have got on duty with you and you can phone one of your other team members to help you out [pause] on the whole, and you know if they can't then you have to hope that your band seven is going to help you, either personally or get help from another clinic. At the weekends you're really relying on your colleagues in neighbouring clinics to be able to bail you out. (Marie: senior nurse: primary care)

Me: *It sounds like staffing is quite problematic at times. Is there not a contingency plan if things go wrong?*

[Laugh] No, it really is a case of just hoping someone will help you out. Everyone loses out when they starve services of staff. The patients, the staff, everyone. [Pause] (Marie: senior nurse: primary care).

Me: *How do you feel about all that?*

Well it's obviously a worry to us all, and to be honest it's been a problem for a long time now, but I think it's getting worse. I think it was better, more manageable when we were all in small teams. In fact when I think about it, we

used to be able to catch up on paperwork at weekends, but I am going back about a few years. [Pause] (Marie: senior nurse: primary care).

In the first exemplar, Marie allowed us a *historicity* to her observations, noting the worsening staffing levels over the past five years. She articulated that she felt shocked at the current situation, which in turn showed empathy for her colleagues. The term ‘*heart sorry*’ was an unusual phrase, denoting the sadness she felt. She took the stance of an observer, who was witnessing the unpaid hours staff generously gave on a daily basis. Her comment, ‘*If the staff didn’t look after each other, there wouldn’t be anyone left*’ conveyed her feeling that the staff only have each other for support, as opposed to support from management. Marie saw the collegial support as the essential cohesiveness that encompassed the team, without which ‘*there wouldn’t be anyone left*’. In the second exemplar, she discussed how if anything went wrong she was reliant upon her colleagues and manager. Her text relayed the autonomy that practitioners are faced with in primary care, and the possible severity of the situation. I can personally relate to her text, and how quickly things can go wrong in primary care. Marie has timed visits that need to be completed in a timely manner, such as medication administration. If a delay occurs, perhaps due to a patient’s health demands, then other timed visits are compromised. Anecdotally, Marie describes a common situation regarding weekends and bank holidays, which can run on minimum staff numbers with no real back-up plan. When she said that she was relying on neighbouring teams ‘*to be able to bail you out*’ this captured the lack of resources available to her and the heavy reliance upon good fortune and chance. She summarises how the lack of staffing has repercussions for staff and patients alike. Marie’s texts allows us to see the changes which have occurred, and how the changes have affected her practice, and indeed patient safety.

Mel

Mel is a senior practitioner in primary care and describes how she developed the interpersonal relationships in a new role, in a new service that she undertook.

So I spent time with various people, social services, [primary care provider], getting to know what they needed, and the [specific primary care service] and

they were very wary of me in this new role; “Who does she think she is?” So I thought right I need to get round this and befriend these people. I spent time with them and went out and worked with them and then said, “Right you’ve showed me how you work, I’ll work in your team for a bit”. I just needed to get to know how they did things because it was very different to [location] and in some ways parochial. Really in some ways I got a lot of friends through that and I stayed there. (Mel: senior nurse: primary care)

In this exemplar, Mel recounts how she managed to change her peers’ perception of her new role, and facilitate trust and friendship. She described how, using a practical and hands-on approach, she established good inter-personal relationships, which motivated her to stay in the role. She clearly articulated the journey from feeling like an outsider who the other staff viewed with mistrust, evident in the phrase *‘Who does she think she is?’* to the point where trust has been established and she said, *‘I got a lot of friends through that and I stayed there’*. Mel demonstrated her own self-awareness within the situation, and her own knowledge of how important collegiality was to effective working relationships. She acknowledged the necessity of teamwork and collegiality in her words: *‘right I need to get round this and befriend these people*. By saying *‘these people’* she showed that she was not part of their culture, but demonstrated an awareness that she must become an accepted part of that group. Mel further acknowledged her need to understand and fit in with the new culture in the phrase: *‘I just needed to get to know how they did things because it was very different to [location] and in some ways parochial’*. The word *‘parochial’* means a limited or narrow outlook or scope, perhaps in Mel’s view rather reminiscent of historical nursing practice. However, she visualised the bigger picture that was apparent to her, and did not focus on changing practice in this aspect of their behaviour. Her aim was to achieve the support of colleagues which she saw as an invaluable part of team working. Mel demonstrated in her description of her actions that she was able to see the constituent parts, which would influence the whole, from the perspective of the hermeneutic circle, and in turn the whole would influence the constituent parts. Mel then went on to speak about other elements of colleague support:

I suppose the only comment I would make is, I think I’ve had quite, I’ve gone quite a long way in my career and I’ve worked with some good people who’ve

helped that along the way, and I feel really sorry for people, in a way who are starting out on a nursing career now because I think they're gonna have it really hard, [pause] no, well I wouldn't do it again. I don't know what I'd do but I wouldn't because, I just think it's all gone bad, and it's a shame, I think, you know, you go into the hospital and, and the nurses are, they're run ragged, they're completely run ragged, they're stressed out, it's a shame because that rubs off on the patients doesn't it? (Mel: senior nurse: primary care)

Mel then describes the support she experienced when she was being bullied, an account that I present under essential concept 5, which explores negative collegial relationships.

I had an office manager, who was very supportive, and all the other [specific role in primary care], were all very supportive, because, these three bullied them a little bit, but picked on me more because I was in the leadership role, so they, they weren't happy either, so yeah, it was a horrible time, horrible, really horrible time, it nearly finished me to be honest, but yeah, but I just, I just had, I had it, I knew I was in the right, and I had the best intention.

(Mel: senior nurse: primary care)

Mel talks about having had an accomplished career, which was assisted by the support she received from colleagues. She then reflects upon the challenges that lie ahead for new students, before admitting that she would not choose nursing if she were just embarking upon a new career. She looked upon nursing as having 'gone bad'. She observed that hospital nurses have excessive workloads, in her words 'run ragged', an idiom she repeated, adding the word 'completely' to emphasise its meaning. Generally speaking, the idiomatic meaning is that of exhaustion and of course the verb 'run' is generally used as an intransient verb, as it lacks the literal meaning of running or jogging, and is more in context with the running of a machine. However, when Mel described the nurses as 'run ragged', for me this produced the imagery of the nurses literally running around, a picture supported by saying '*that rubs off on the patients doesn't it?*' Mel appears to be describing a situation where the nurses have multiple and complex tasks, meaning they are physically and mentally exhausted, and patients are witnessing this.

Mel was not just giving a negative account of the present day nurse's role; she was making comparisons with her own historicity. Her later comments in the exemplar cannot be separated from the first part. Mel has had a long and accomplished career, and a career that is ongoing. She was not voicing an intention to leave nursing but she reflected upon how nursing had changed. When I first looked for the emerging concepts, I took only the first half of this first exemplar, as it represented Mel's valuing of colleague support. However, as I relooked at it in its place within her interview, I felt this needed to be in the context of how she said it, not just so that I could consolidate my own theory. It is important to me that I do not manipulate the data to portray what I want it to say. Mel's comments appear to portray the importance of positive colleague support as she clearly saw this as one of the attributes that allowed her to have a successful career. Perhaps the later comments relating to how nursing has '*gone bad*' were due to the lack of colleague support in contemporary nursing, which has been devalued because of the excessive workload.

Dawn

Dawn is a senior practitioner in acute care and commented upon the support from her immediate colleagues:

I have a nurse manager, and I get support from doctors in the [acute care setting]. It is very supportive. My nurse manager is fantastic. They are supportive with study time while I do my [specific qualification]. (Dawn senior nurse: acute care)

Dawn spoke very positively about her current role, and the support that was evident in her environment. Her language was clear and decisive, making direct reference to her nurse manager and the doctors. It was apparent that her current role afforded her a safe *dwelling* place, where she felt nurtured to develop. This was in stark contrast to other observations she spoke about in previous roles, where she was frightened to raise concerns for fear of the consequences. By looking at the whole in relation to the parts we see the juxtaposition of happiness and sadness, making her comments more poignant.

Adam

Adam, a senior nurse in acute care, made the following comments. His views are slightly different as he tells how he found the area where he felt most comfortable to work in, as he felt more comfortable in a male dominated environment.

In my training it was 99% women. We had to do everything, but I wasn't treated well. I was treated differently. In [acute care setting] they were nearly all men, the [medics], [medical assistants], [healthcare assistants], they are all very nice to you. This is where I feel comfortable. [Pause]

Me: That's interesting. Can you tell me some more about it?

Adam: Well I think it really matters that you choose the right departments. Men don't choose the wards. You go to [acute care setting], they choose [specific role in acute care], paramedic, they know where to work. Men specialise and go into different sections or factions. Men learn during their training where suits them. (Adam senior nurse: acute care)

Me: So it was a conscious decision to choose [Acute care setting]?

Adam: Yes, after my nursing training I decided to go into being a [Specific role] and did training for six months and then trained as a [Specific role] in [Location]. That was what was right for me. (Adam senior nurse: acute care)

Adam referred to a specific acute care setting where he felt comfortable, and I assume safe. Adam had seemingly experienced some unsupportive colleague interactions from some female nurses and had therefore decided he preferred male colleague support. Adam had made a conscious decision to choose this comfortable setting, demonstrating an *authentic* mode of *being* and a safe dwelling place for his development. I acknowledge that Adam was making some generalised assumptions about gender in nursing, which I am not ignoring. I am, however, concentrating upon

the fact that he was telling me about where he feels most secure, and that he feels a positive influence from the collegiality in that setting.

Caroline

Caroline, who is newly qualified, and made the following observations about the collegial support during her nurse training:

In [location] it was quite tough, as you have a lot of academic work to complete as well as being on placement. I worked much harder than my friends who were doing other degrees. I nearly said normal degrees then [laugh]. I had to spend all day in placement while they could just mess around. But I enjoyed most of it. I think you make good bonds with nursing friends, cos you're kind of in it together. When I spoke to my other friends they couldn't always understand what my issues were cos they just weren't in it, you know. We all still meet up and go out together, but it's not the same as when we were together. I moved back home to my parents when I finished and got a job on the [primary care service]. I love being back home, but it's not the same as in [location].' (Caroline: newly qualified staff nurse)

She then went onto discuss her first post-registration job in a primary care setting:

In [location] there was a sense of being part of a team. I think some of them stayed just for each other. The band seven tried to get everyone to be a team player. She was a team player, and always helped us out, but when she left we got a band seven who just wanted to sit in an office somewhere else. We never saw her. (Caroline: newly qualified staff nurse)

Me: *It sounds like the team were really influenced by the band seven's behaviour? How did the team change when the management style changed like that?*

Caroline: *Well, I think she was a really good role model, certainly to me. She made time to listen and seemed to know about everyone, you know things that were going*

on with them. I think that's important. I think when she went everyone just went back to relying on each other like I said. It's a shame. (Caroline: newly qualified staff nurse)

In the first exemplar, Caroline spoke about the importance of her friends. She divided the friendship groups into two halves, her '*nursing friends*', and her '*other friends*'. She differentiates them, with the nursing friends having really '*good bonds*', explaining that they shared a common tie when she said, '*you're kind of in it together*'. She also observed that the '*other friends*' failed to understand her '*issues*', which I interpreted as being related to clinical practice. There was evidence of being an '*insider*' in this text, since other friends were not able to understand what happened '*inside*' the culture of nursing. The notion of having a shared understanding, with its own insider language, behaviour and humour, appeared to give Caroline a sense of belonging within the culture. I could relate to how she made this division between nursing friends and others. A shared sense of humour relating to anecdotal events within practice will generally escape non-nursing friends, but be hilarious to nursing colleagues. The concept of insider behaviour and belonging to a specific culture was an interesting concept one which I will revisit in the discussion Chapter.

Caroline also spoke of her sense of belonging in another way, when she related to her physical location. She mentioned she had returned to her parental home, and compared this to living in halls of residence at university. Her parental home no doubt represented her *safe dwelling*, and held all that was familiar to her, especially the love of her parents. She said '*I love being back home, but it's not the same as in [location]*', which seemed to mean that she missed the support and camaraderie of living in halls of residence at the university. Her return '*home*' is also likely to have reduced her independence. I relate to these observations through my eldest son who was bereft when he finished his law degree and returned home to live to commence post graduate studies. I recognised that he was grieving for his loss of independence and the friendships he had enjoyed at university. This camaraderie is indeed a powerful influence on one's *being*.

In the second exemplar, Caroline's text allowed an insight into her experience as a new member of staff in a new role as a staff nurse. Despite being unfamiliar with the team's dynamics, she had initially understood the concept of feeling part of the team,

of belonging. She attributed this '*sense of being part of a team*' down to the behaviour of the more senior manager, who she notes as being a positive role model. She reflected upon the specific manager's departure metaphorically, as like the 'team spirit' leaving, observing her successor as being aloof and inaccessible. She also referred to the strength of colleague support as '*I think some of them stayed just for each other*', and reinforces his belief later in the conversation by confirming '*everyone just went back to relying on each other*'. Caroline's text was reminiscent of Marie's thoughts, when she referred to the pressures of the role, and not wanting to let colleagues down. Caroline appeared to make her comments from an observer standpoint, and not from one who was experiencing the collegiality first hand. She was seeing how others in the team valued the support from colleagues. This was in contrast to when she spoke of her experiences in her own training, in the first exemplar, when the collegiality is felt personally. Caroline's own experience of colleague support seems to have allowed her to recognise how important it was for the other nurses. Perhaps this was to do with her transition into the new role, and into the new team. In the second exemplar, she was not viewing things as an insider, as in the first exemplar, when she doesn't appear to have experienced a sense of belonging in the new culture.

All of these extracts described the positive impact that participants have experienced through being in a supportive culture, with positive collegial support. Marie observed it was the support from colleagues that allowed them to cope in a situation that was pressurised and stressful, but was aware staff cannot endure the pressure indefinitely, and they start looking for other jobs. Marie also intimated that she felt there was a lack of managerial support when she said, '*If the staff didn't look after each other, there wouldn't be anyone left.*' This was also reflected in Caroline's observations, when she said, '*I think some of them stayed just for each other*'. Caroline also saw the visible support from the manager as invaluable to the team. These disclosures demonstrated the strength of collegiality, and the potential positive effects that it could have upon nursing. Jean's comments are also very positive and encouraging, as she shared her observations of her three part-time roles in different healthcare settings.

As a researcher and a nurse, a disclosure pertaining to my own thoughts on this area is relevant here. My initial thoughts of the culture of the NHS prior to this study had been coloured by the negative media attention created by the high profile government

investigations (Francis, 2013; Kirkup, 2015). However, there is a balanced argument to engage with here. There are many positive attributes pertaining to culture, not least the powerful effects of collegiality. If we consider that nurses' careers can often span decades and this is generally due to the satisfaction of the job, feeling that one has made a difference, and of peer support, not just their resilience under pressure. On the subject of collegiality, I would venture that this has been one of the strongest positive influences in my nursing career. I consider the peer support and friendship I have been privileged to enjoy over the years has been an exceptional motivator. When resources have been limited and staffing low, collegiality has inspired me to continue, not wanting to let other nurses down. When my own father was diagnosed with terminal cancer, I felt the allegiance to other staff; a magnetic pull to keep me in work until my father's needs outweighed all other loyalties and I made the decision to resign to care for him. Retrospectively, I wish that my sense of collegiality had been less consuming in those final months of my Dad's life but then I continued to receive support from past colleagues, for which I am indebted.

The concept of *being-with* is how Heidegger (1927/2010) describes our relationship with others in *being-in-the-world*, and brings in the notion of *care*. He advises us that if we seek *authenticity*, then we need to be aware of the influence other people have upon our actions and more broadly upon our identity. This idea of inter-subjectivity leads Heidegger (1927/2010) to suggest that since *Dasein* is with others in the world and not alone in the broadest sense it assumes a mode of *distantiality*, which could be described as indifference. Heidegger (1927/2010) conceptualises this as being 'dissolved in the world of the-they'. This is not to say that *Dasein* can never experience being alone; on the contrary, by virtue of the fact that *being-with* is an essential mode of *being* then *everyday Dasein* can experience being alone and therefore loneliness. The underlying assumptions made in relation to *being-with* are that *Dasein's being-in-the-world* and *being-with* are interwoven with one another, and *Dasein* cannot be unconnected with the everyday world, and our *being-in-the-world* is influenced by historical, cultural and socio-economic factors. Again, we acknowledge the need of the silent call of conscience to bring *Dasein* out of its *inauthenticity* of everyday life to take responsibility for itself and its possibilities. Heidegger (1927/2010) proposes that the study of our relationships to objects and people we interact with in our environment will allow us an understanding of *Dasein*. In order to see our responsibilities and

possibilities, we must understand our self as individuals, not through others or as a part of *the-they*, as by taking on an *inauthentic* existence we ignore the reality of our own relationship to the world. Gadamer (1975/1996) stresses that by understanding others, we gain an understanding of our self. In applying Heidegger's (1927/2010) theories to the text of participants we observe *being-with* others is an important issue to them. The participants demonstrate a *concern* and *solicitude* for their colleagues and in doing so demonstrate an understanding for themselves and their own needs for others to show concern for them.

Essential Concept 5: *Being-with (Mitsein)*: negative collegial relationships

Introduction

Essential concept 5 explores the data relating to participants' experiences of negative collegial relationships in nursing. It investigates how participants have behaved when faced with this uncomfortable phenomenon. It was clear this subject was an emotive one, which effected their working environment and their ability to stay in the job. Participants allowed their vulnerability to be viewed when discussing this issue, and provoked feelings of distress and anger in relating the information. I also add my experiences of feeling bullied and speak about how this affected my own role in clinical practice. The concept of negative colleague support addresses the aims of this study in exploring how this has affected their individual and professional accountability, and its impacts upon patient care. Using the Heideggerian theory of *being-with (Mitsein)* I seek to view this phenomenon through a hermeneutic lens.

Essential Concept 5

In Heideggerian terms, *being-with (Mitsein)* describes how we interact with others in the world. In this essential concept, the interactions and influences are of a negative nature, and have the potential to cause distress. Bullying was an issue that was referred to by all of the participants and took various guises, from covert to unconcealed negative behaviour. For some it was a situation that was endured, for others it made them leave the role, and for others it demanded confrontational skills.

Mel

Mel spoke about being bullied by three colleagues whilst they were all working in senior positions in primary care:

I had a really bad time with the other three in the service as I wanted them to do more and they didn't want to do any more. But when you are in a leadership position and you've got KPIs [key performance indicators] to meet, develop the service and justify three people sitting on [specific roles], they've got to be autonomous practitioners. So there was a big problem and basically I reported them for bullying and then they reported me for bullying. And basically if anyone was a winner in it, there was proof that they did bully me, as the three of them ganged up on me. They were moved out of the service...I did take a grievance out, it went on too long, but that was [primary care provider], so, you know, [specific hospital trust] is completely different, can't imagine it's much better if I'm honest, it was brushed under the carpet for a long time and I suffered for quite a long time before they took notice of it, but, I, no I had a, a very nice, too nice, manager, who tried to, make everybody friends, the individuals I was dealing with you can't be friends with, they're not, you know what I mean, they, they were on a mission, and, she needed to be tougher, quicker, and the thing that pushed her into being tougher was because I pushed it, and I took it to the [union], and they advised me to keep a log of absolutely everything so I did. I had 40 pages of logged information that you couldn't argue with cos it was all factual and you know, people in the team backed it all up, and when she saw that there was no going back, and actually witnessed one episode of the state I was in one day that she just took action, and took it further. She did then meet a block herself from her senior manager who was [person's name], who was the one that came over to [specific hospital trust] with us, and she said, oh, just tell her to get on with it, kind of attitude, and she tried to brush it under the carpet. But we took it above her head, yeah, yeah because, I had an office manager, who was very supportive, and all the other [specific role in primary care], all very supportive, because, these three bullied them a little bit, but picked on me more because I was in the leadership role, so they, they weren't

happy either. So yeah, it was a horrible time, horrible, really horrible time, it nearly finished me to be honest, but yeah, but I just, I just had, I had it, I knew I was in the right, and I had the best intention, you know. (Mel: senior nurse: primary care)

Mel was quite expressive when she spoke about this difficult period in her career, and although some time had passed, the emotion still appeared raw. The most dominant emotions were anger, and a sense of having been severely hurt by the whole situation. I felt at the time of the interview that this experience provided the motivation for her to become involved in my study, and immediately following the interview she told me that she had felt it cathartic to speak about it. Mel had obviously found the situation untenable at the time, which led her to report her colleagues. Her voice conveyed the shock that they had made a counter claim for bullying, a situation which she clearly had not expected. I sensed that their counter claim had wounded her deeply. She went on to admit that they were all very hurt by the experience when she observed, '*basically if anyone was a winner in it*' meaning that they all lost a lot in emotional terms.

The fact that three colleagues perpetrated the bullying meant there was a power imbalance, which would have made it even more difficult for Mel. However, she was eventually vindicated, and the other staff were moved to another area. Mel infers that the issue was handled badly, as she described her manager lacking the strength to manage it more effectively. Mel demonstrated strength of character in raising her concerns, displaying an *authentic* mode of *being*, although the process of confrontation was clearly not without a great deal of *angst*. However, returning to the whole, the experience did allow her to realise her own *possibilities*, and afford her a safe *dwelling* place in which she could develop professionally. Mel's original motivation for her grievance was to provide a better service, with more efficient staff. It was not initially because they were treating her in an undesirable manner. She said, '*I wanted them to do more and they didn't want to do any more*' so her motivation was for altruistic reasons, and not personal ones. She personally seemed to pay a very high price in the name of service improvement. Her commitment to her professional accountability was extremely admirable and took courage and commitment to achieve.

Mel also described the collegial support she received during this traumatic period in her career. She described the experience using the term '*horrible*', emphasising this word three times in succession to make the point more poignant. It seems it was the support from peers that allowed her to carry on with the grievance, along with her desire for justice; a point she makes by saying '*I knew I was in the right, and I had the best intention*'. I would interpret Mel's comments to mean that she saw her actions as also helping her colleagues who she witnessed also being bullied by the same people. Mel demonstrated a courage and resilience, admitting that '*it nearly finished me to be honest*'. It is interesting that both the negative and positive aspects of collegial relationships stand side by side in her text. The positive support was perhaps the stronger influence in the end in that it '*nearly*', but did not actually, finish her. It would appear that the positive support stopped her from leaving the profession, along with her sense of justice and good intentions, which led her to embark upon the grievance. Mel encounters problems in trying to escalate the complaint, with her immediate and senior managers both trying to evade the issues. Mel's ability to adopt an *authentic* mode of *Dasein* is clearly visualised, as too is the degree of *angst* that occurs with the confrontational process.

Caroline

Caroline, a newly qualified nurse described her feelings of discomfort relating to two other nurses in a primary care team:

When I moved to [location] team there was a couple of nurses who had been there forever, and they weren't very nice with me. I was the new girl, and they didn't make me feel welcome. It was awful if I had a whole shift with them. If I brought back visits they would roll their eyes. The patients didn't particularly like them either. If they weren't there it would have been a nice team. (Caroline: newly qualified staff nurse)

Caroline's discomfort, created by the two senior members of staff is clearly articulated. She disclosed how they made her feel unwelcome and inadequate. The words '*If I brought back visits they would roll their eyes*' demonstrated they were disapproving

that she had not completed all her allocated visits. She also ventured that she felt the two nurses in question were unpopular with patients too, leading me to interpret she was not alone in her assessment of them, and their interpersonal relationships had an impact upon patient care. Caroline made no mention of whether she had raised her concerns about them to anyone, although returning to the whole, from the parts, she did leave the primary care setting to take up a position in acute care. Caroline reflected upon the fact that the two nurses influenced the entire team when she said, '*If they weren't there it would have been a nice team*'; inferring that the other members of the team had more positive relationships with her, and perhaps accentuated the negative attributes of those two nurses. She observed that the two nurses had been in the team for many years, and their behaviour perhaps not confronted. Reflecting on Caroline's text, left me with a sense of sadness that she was being made to feel so uncomfortable by colleagues. She was young and inexperienced, and needed to feel safe and nurtured. I would also add that I possibly felt the anxiety of a mother, as I have a daughter of a similar age, and possibly projected how I would feel if it were her being treated in that way. This is illustrative of the many stances researchers take. Here, as well as the stance of a researcher and a nurse, I am also a colleague, a peer and a mother. Lawler (2002) articulates that the use of self through one's own experiences can illuminate new meanings.

Gemma

Gemma, an experienced nurse, described a situation whereby her managers made her feel threatened, an exemplar that was presented earlier when discussing whistleblowing; she says,

There was a time when the workload became just too great. I involved the union because I complained that we had no time to manage. That the workload was too great. But then the management got HR in and said that I wasn't managing. It became a punishment, and I felt penalised. It was a terrible time. I didn't lose my job, but I wouldn't do it again. (Gemma: staff nurse: acute care)

Although this text has already been presented under the concept of self-protection, it is also applicable under this concept of negative collegial relationships. Gemma

described how she raised her concerns about the excessive workload, as this was affecting both staff and patients. She commented that she and her colleagues '*had no time to manage*'. Effectively, she was saying that the environment was unsafe. This seems a valid concern, and if such concerns were not raised and an incident occurred, questions would be asked of Gemma's individual and professional accountability. However, by acknowledging that her accountability was compromised by excessive workload demands she faced punitive managerial actions. Gemma described how her managers turned her concerns into a performance management tool, asserting that she was not managing. This approach seems to have been used to silence her concerns, and Gemma concluded by saying she '*wouldn't do it again*'. Gemma can be seen to be displaying an *authentic* mode of *Dasein* in raising her concerns. However, the consequences encouraged her to adopt a self-protective and *inauthentic* mode of *Dasein*.

Dawn

Dawn, currently a senior nurse, described her experiences of being a junior staff nurse:

You have patients which are allocated to you; you are totally responsible for them. You work autonomously. I rarely got support from colleagues if I am honest with you. It was a shock. I was very sad. I would have eight patients in a normal day. I think it was the ward. It was a weird environment. It depends upon people. I got no support. It wasn't just me, it was with everyone. Ward managers were office based and not involved in the care of the patients. On the one occasion I asked for help, they said I am sorry I am sending emails about you. You are not coping. I thought that was ridiculous. Because I asked for help.
(Dawn: senior nurse: acute care)

Dawn described the situation of being a new member of staff on a new ward, and in a new country. Dawn observed that she did not experience help or support from either her colleagues or managers. She described a situation where on a ward environment she was forced to work autonomously. She described the new environment as '*weird*', meaning it was strange and unfamiliar to her. She also used the word '*shock*' again, alluding to the unexpectedness of the situation. She said that in her opinion all the staff

behaved in an autonomous manner; in her words, *'it wasn't just me, it was with everyone'*. When Dawn asked for some assistance, presumably with patient care, she was met with the manager telling her that she was being reported for *'not coping'*. She decried this as *'ridiculous'*, as in her opinion it is extremely reasonable to elicit assistance. Dawn's text demonstrated her adoption of an *authentic* mode of *Dasein*, in Heideggerian terms, in raising her concerns and asking for help. She also demonstrated her professional accountability, in trying to fulfil a high standard of patient care. However, her concerns were silenced by the manager's reaction in threatening, or indeed actually, reporting her for not coping.

Dawn and Gemma's texts have a similar theme. Both raised their concerns about the excessive workload, and both experienced angst in the form of adverse reactions in response to their actions. In both texts it was observed that the managers who received the reports viewed the concerns as criticism and chose to adopt a performance management stance. Both participants offered outrage to the reaction, and both felt they were judged unfairly. The managers' stance is clearly reactionary, and seems to portray their insecurity as they appear to deflect attention from the presenting problem, that was staffing, back to the individual raising the concern. Both participants demonstrated their courage and commitment to patient care but experienced considerable angst, especially in Gemma's case, where it escalated to human resources becoming involved. In both cases, they were at a power disadvantage and had tried to report concerns using the appropriate channels. The experiences perhaps also demonstrated that the managers in question had failed to address the actual problems, and perhaps used their power inappropriately.

Marie

Marie observed feeling bullied during her nurse training, and again she contextualised this within the historicity of the time. She commented,

Back then we all felt bullied but it was just part of the course you know. You were not singled out and you know the ward sisters, not all of them, but you know there were a few characters and a few staff nurses as well where they would make your life hell. You were expected to do things in a certain manner

and in double quick time and they weren't shy about yelling at you in front of the whole ward, but the plus side of that is that the patients always backed you up, they'd give you a sweetie or a kind word and certainly colleagues did as well, and at the end of the day most of the things you got shouted at for were for the patient good, they weren't petty things. (Marie: senior nurse: primary care)

Marie's text was again very powerful, conveying a historical picture of nursing in the seventies and eighties. Against the backdrop of her previous text, she reported in a matter of fact way that bullying was part of the culture, and that everyone felt the same way. She mentioned this was how everyone felt because she did not feel singled out or targeted, which she seemed to think made it somewhat easier to bear. However, she received support from the patients and her peers, which she also saw as part of the *everyday* of the culture. There was almost an 'us and them' in her tone, whereby she saw being bullied by seniors and doctors as 'them', but it is a *facticity* that she received collegial support and patient support. At no time did she express a non-supportive element from her peers, and this support was taken for granted. She also justified the admonishments from her superiors as being in the patients' best interests by saying, '*the things you got shouted at for were for the patient good, and they weren't petty things*'.

The above texts all convey the discomfort and distress participants have experienced during their nursing career that were attributable to the behaviour of their peers or managers. I could personally relate to many of the comments made, especially to Marie's where some years ago it was commonplace to hear staff publicly admonished across a ward environment. I also felt a sense of disappointment that when participants had the courage and adopted an *authentic* mode of *being*, their managers failed to display a similar *authenticity* in dealing with their concerns. As noted in the earlier text pertaining to Gemma's experience, she had later adopted a self-protective mechanism in relation to whistleblowing fuelled by her *priori* experience. Perhaps this is a common response and has a greater bearing upon raising concerns than I first anticipated and may be grounds for further research in the future. Another thread that comes through many of the participants' experience is the issue of staff being silenced for raising concerns. In Gemma and Dawn's texts this is particularly striking as both

try to raise concerns about excessive workload and are accused of not coping by their managers. In both exemplars we see the participants at a power disadvantage, and in both cases this seems to have been used against them. In Mel's exemplar concerning the treatment she received from three colleagues, the resulting action is not to discipline the perpetrators, but instead to just move them to a different area. As I was reading through the interview transcripts I reflected upon the frequency that I have seen this situation occur in clinical practice, whereby managers move the person creating problems to another area, instead of tackling the issues. I recalled the frustration I had felt on many occasions, as I had seen this happen, but then began to question my one sided version, and wondered if in their position, I may have done the same, believing I was giving them another chance.

In Heideggerian terms, *being-with* others is an important element of *Dasein's* being as it is through its relation with others and their influences upon it that *Dasein* gains understanding of itself (Heidegger, 1927/2010). The ontological characteristics of *Dasein* are the *they-self* and the *authentic* self, which can equally be assumed as *existentialia* and not *existentiell* modes of *being*. The term *existentialia* is an important term of reference here, as Heidegger (1927/2010) uses this to denote the characteristics of *Dasein*, which are present when we analyse the *everydayness* of *Dasein*, and literally means 'what it is like to be'. *Existentiell* on the other hand refers to an individual's own understanding of their *Dasein*, a self-understanding, which has been sought and clarified through existence. When referring to *Dasein's* relationship to *the-they* and society, Heidegger (1927/2010) makes the following observation, demonstrating how it is easy to lose oneself in *the-they*.

This being-with-one-another dissolves one's own *Dasein* completely into the kind of being of the others, in such a way, that the others distinguished and explicit vanish more and more. (Heidegger 1927/2010:126)

Heidegger's (1927/2010) theories can contribute to the debate on the negative collegial relationships by exploring why and how other people's behaviour influences our own. In the text, participants have described 'what it was like to be' in the context of their *lifeworld*, when there has been negative behaviour towards them. For Mel and Gemma, the confrontation of others had been difficult and painful but had led them to

a place of self-understanding. Heidegger (1927/2010) notes that individuals interpret and make sense of experience, not just in respect of the immediate situation but also with experience gained through our own personal history. Furthermore, Heidegger (1927/2010) makes the observation that in order to understand others and their behaviours we must first gain an understanding of ourselves and our interactions with others. The following quotation captures this thought:

The disclosedness of the Dasein-with of others which belongs to being-with means that the understanding of others already lies in the understanding of being of Dasein because its being is being-with. This understanding, like all understanding, is not a knowledge derived from cognition, but a primordially existential kind of being which first makes knowledge and cognition possible. Knowing oneself is grounded in being-with which primordially understands. (Heidegger, 1927/2010:124)

Essential Concept 6: Care and *solicitude* in *being* a nurse relating to the complex challenges in care provision

Introduction

This section explores the concept of care and *solicitude* in relation to *being* a nurse, and the complex challenges that are apparent in the everyday *lifeworld* of participants. Inevitably, parts of this section overlap with the cultural issues that have been previously mentioned. Holistic care provision encompasses the notion of holism, and is incorporated into the NMC code of professional standards (NMC, 2015a: section 3), charging nurses and midwives, ‘to assess and respond to people’s physical, social and psychological needs’. It is therefore vital that participants’ experiences on this subject are heard, including the ways in which they feel their professional accountability is compromised. I also share my own experiences in relation to their issues, providing co-constitutionality to the data. With reference to the studies aims, this chapter explores how their professional accountability is experienced in relation to patient care.

Using Heidegger's (1927/2010) philosophy, I use the concept of *care* (*Sorge*), *concern* (*Besorgen*) and *solicitude* (*Fursorge*), which refer to the ways in which *Dasein* exists in the world. *Care* (*Sorge*) is described as a structure of our *being*, and is depicted in the ways we relate to and communicate with things in the world. *Besorgen* relates to the *concern* we have for others. *Solicitude* refers to the ways in which we interact with others, in our *being-with* and *being-in-the-world*. The essential concept of *care*, relates back to the care structure and the potentiality of *Dasein*. The concept of *solicitude* explores the ways in which nurses interact with others, and by this I refer to nurses' *solicitude* for their patients. *Solicitude* depicts the two ways in which we fulfil care to others, by *leaping-in* and *leaping-ahead*.

In nursing it is often necessary to give holistic care at times when a patient cannot meet their needs for themselves, and *leaping-in* allows nurses the capacity to meet their needs. At other times *leaping-ahead* is the most appropriate action, when nurses facilitate empowerment through advice and encouragement. These two strategies are of course equally applicable to peer interactions and mentoring, to nurture and develop one another. I have chosen, however, to align this concept to that of the nurse-patient relationship, as this is fundamental to the art and science of nursing and seek to explore how professional accountability relates to patient care. On this point, however, I investigate how professional accountability is impacted by the social and political drivers apparent in contemporary healthcare, and how participants have experienced this. The issues and emotions conveyed through the texts offer an insight into the ethical dilemmas faced by nurses in not having enough time to nurse, in order to fulfil their obligations to the patient. Participants conveyed their frustration and anger in finding themselves in these compromising positions.

Heidegger (1927/2010) reminds us we are always *in-the-world* with care, never with indifference, and it is through the structure of care that we interact with our environment, objects, animals and other people. The three dimensions of the care structure allow us to see how we exist in the world. First, there is a *facticity* of being born into a certain culture, time and place, a situation that just happens and is governed by the *temporality* of mortality. Heidegger (1927/2010) calls this *facticity of thrownness*, referring to literally being thrown into the world. Second, there is a *fallenness* and *inauthenticity*, which is the way in which we live, conforming to societal

norms and not realising our potential. Third, there is *authenticity* where we choose not to conform and imitate others, instead realising our potential and possibilities. Heidegger (1927/2010) observes that *Dasein* is both *authentic* and *inauthentic* throughout our lives.

Essential Concept 6

Throughout this study, there have been multiple references to how nurses interact with and *in-the-world* so it is vital that I now look at the effects *solicitude* and *concern for others* have upon the patients we nurse and the nurses' perception of this on their own professional accountability. Below are some exemplars of text that portray the participants' feelings of how the finite resources of the NHS have had an impact upon holistic nursing care.

Marie

Marie, an experienced nurse working in primary care, spoke of the way in which a shortage of staff and a high workload impacted upon the holistic nature of patient care and how she felt '*blinkered*' into purposely not looking or asking about other problems that may be apparent, as there was no extra time to deal with them in such a high pressure environment. Her sense of sadness at not being able to holistically nurse and spend time with patients was clearly audible in her text.

When you visit patients, you don't want to see the other little things as you don't have the time to and you're feeling bad about it because you know the commitments you have and you don't just have that extra few minutes... You know that you are under pressure or the teams are under pressure you are kind of short-changing them [the patients] I think on the communication front... I feel bad, but I can feel a bit impatient because somebody can't hear me at the door and you know when they'll take a long time to get to the door, and then they decide they want to go to the toilet. I hear them say "oh it's another new face" and your patients don't like seeing a different nurse every time they have a care episode. So I think maybe the confidence in the treatment and the care that they're being given, they might feel that care is compromised or not as good as

it might otherwise be. And I suppose that it's strangers, different strangers coming into their home. You wouldn't want that for yourself or your mum? It has a knock-on effect when you get back to the clinic because you know that there aren't many staff, so you are all rushing and then you have more of a tendency to forget to pass things over. You communicate in double quick time. All these things have an impact indirectly on patient care. I think it's more difficult to have consistent quality of care when staffing is low. (Marie: senior nurse: primary care)

The second exemplar from Marie described the way in which she felt service development has affected her role in the primary care setting:

I think patients are encouraged to be more involved in their care and everything is supposed to be more patient focused, which is fantastic. But the amount of paperwork in nursing. Certainly, on the community, the amount of scribing that you have to do that is very, very repetitive, at the same time, time consuming and this is morale seeping as well and this is in spite of computerisation which should have made things I think easier, instead, it seems to have proliferated the amount of scribing that we have to do you know. 16 years ago probably even 10 years ago the most technologically advanced piece of equipment in a [primary care service provider] room was an answer machine and maybe one mobile phone and I don't think we even had our own fax; we had to get that through the doctors' surgery or whatever and so I think sometimes we're creating paper to satisfy things that are not related to good patient care or improve patient care or improved patient safety although it's dressed up as that. Not that long ago, perhaps five years, no probably 10, I would go into a patient's house and sit with them and write a care plan. To me that is patient centred care. I had the time to talk and assess them properly. I would discuss their care with them. Now I just give them a core care plan. That's not patient centred. I write notes in their house, then I go back to the clinic and write them again in their clinic notes. This is the 21st century and we don't have one computer system we can all use, it's laughable really. And what is really laughable, we still send faxes [laughs]. Which other industry or organisation still use faxes? [Laughs]. (Marie: senior nurse: primary care)

In the first exemplar, Marie talked about the frustration she felt in not having enough time to care for her patients in a primary care setting. She admitted to trying not to see '*the other little things*', because she had no allocated time to deal with them. She was clearly compromised by this, and wanted to properly assess and manage their care, and give time to talk to them about their care and things in general. The lack of time she can give to people to talk is summed up in her phrase '*you are kind of short-changing them [the patients] I think on the communication front*'. She observed how the busy workload impacted upon the continuity of care, with different nurses attending on each visit. She felt this aspect affected patient care in several ways, with a lack of relationship building leading to a possible lack of trust in the treatment, and the patient feeling that '*different strangers [were] coming into their home*'. I could relate to this as a nurse working in primary care, but also when caring for my father at the end of life. As a carer I felt a sense of being let down when staff I was unfamiliar with visited. For me, it also meant I would have to summarise his condition and tell them what had occurred previously, as the record keeping lacked the punctuation of the personal story that we were living through. Marie observed, '*You wouldn't want that for yourself or your mum*', a phrase that invoked her empathy and identity as she related to her own life and practice values, in that she would not want this treatment for herself or her mother. In Marie's text we heard how the pressure of time was also reflected in the clinic setting, when verbal reporting was rushed and therefore lacked accuracy.

In an earlier excerpt, Marie had traced the historic decline in staffing she had observed in her area of practice in primary care. Marie's story was very poignant to me as a clinical practitioner, having experienced what she described first hand. In an earlier text, Marie had spoken about raising her concerns both personally and collectively with other staff; action that had not been successful. In the second exemplar, Marie illustrated the fact that in an advanced computer technological age the NHS appeared to have less innovative communications processes than the rest of society. She brought up the issue of valuable time being wasted through duplication and the various unconnected computer software. She furthermore observed the issue of information being compartmentalised within each discipline, with handwritten notes remaining unseen by other clinical areas.

Marie also linked back to her earlier thoughts on the fact that care should be holistic, and patient centred. She related that in the past she would have been able to sit and discuss a patient's care with them, involving them in the care planning process. This had changed to generalised core care plans, which she felt are not patient centred. Marie is a very experienced nurse, who is aware of the need for holistic patient centred care, but under the current healthcare system is compromised into giving a lower standard of care. Marie also allowed us a historical perspective of how the technological age has affected her clinical practice. She laughed at the irony that it remained commonplace to send faxes, whilst other sections of society have long since stopped this practice due to concerns about its security.

Mel

Mel spoke of the direct links of low staffing to patient health when she related the fact that when staffing is very low sometimes basic tasks get missed, such as nutritional needs. She said the following in a very direct manner:

Where they're saving money by not filling vacancies, it's affecting patient care. There's less bodies on the floor, and patients are not getting as many drinks, they're struggling to get round and feed them all, and the care's lacking. It's not that staff are lazy or mean or incompetent, but how are they expected to get round everyone when there's hardly any staff?... when somebody ends up really ill because they haven't been given enough fluids and they're dehydrated, they get a UTI and they're really ill and it's a lack of care that's caused it, I'm not being funny, but you know, no mincing our words these things are avoidable, these things shouldn't happen...It was very disappointing to see how the standards have dropped, from working as a [primary care practitioner], and quite frankly they were so bloody busy, in [location], and sometimes there were about 15 patients in a day, but doing the best job I possibly could. Then in this area, with certain individual nurses, who, were very task orientated, who would, because of rushing, would go in and deal with whatever they were in there to do, and ignore everything else that was going on around them. Now, I moved out of [primary care service], because, I wanted to do the holistic care, and I wanted to spend time with people, to make a difference, to sort problems out,

so yes I'm kind of coming from a different perspective, but, to be too busy and to walk away and leave things, must be very difficult. (Mel: senior practitioner: primary care)

Mel's exemplar illustrated the anger she felt, as she cited the reduced number of staff impacting upon patient care. She drew attention to the short-term savings made through employers not filling vacancies, which directly affects patients' health outcomes. Mel observed that it was not the fault of staff being *'lazy or mean or incompetent'* when they were failing to provide basic care. Instead, she noted it was physically impossible to *'get round everyone when there's hardly any staff'*. She gave a simple, yet conclusive example of a patient becoming dehydrated from lack of fluids, then developing a urinary tract infection (UTI). She was direct in her criticism that *'these things are avoidable, these things shouldn't happen'*. Mel articulates her point that the short-term savings for the NHS could have catastrophic implications for patients' welfare. It seems ironic then that hospitals categorise patient harm as *'shouldn't happen events'*, collecting data on a national scale. Mel made the vital observation that inadequate staffing levels directly or indirectly can cause harm to patients. Mel was very vocal about the impact of staffing, and about the public's perception of nurses. She was aware of their professional accountability to patients, and the fact that her ideals concerning patient care were being compromised.

Mel's second exemplar viewed a specific service provider in primary care. She was describing a fairly recent career move and explained that she left that environment as she felt she needed to give more holistic care. She related the fact she would be allocated 15 patients per day, and that, bearing in mind Mel's seniority in this field, would be 15 patients with very complex needs. She recalled how nurses who had the ability to be task focused would complete visits in a timely manner, but *'ignore everything else that was going on around them'*. This task focused approach would not afford a holistic approach to nursing care. She described how being in a situation where you are *'too busy... [so you have] to walk away and leave things'* *'must be very difficult'*, and it seems not a form of nursing that Mel is ever prepared to adopt. She noted that holistic care was about spending time with patients and allowing her *'to make a difference, to sort problems out'*. Reflecting upon this, Mel makes the point that by giving holistic care in the first instance, other problems are alleviated in the

future. When she referred to the '*task focused nurses*', she observed they do not see the whole picture, and in that way fail to address all the problems, which will no doubt surface eventually.

Adam

Adam provided an overview of his perceptions on NHS staffing in his clinical area of work, in the acute care setting:

A few years ago we used to have lots of agency nurses. We ran most shifts with agency nurses. Now we have no agency staff, we recruited a lot of staff. We have to say how many nurses are on each shift. Sometimes at weekends we cancel operations because there is "no bed available". The bed is there, but there are no staff to complete the care. Because I work in [acute care setting] we do not suffer from low staffing. Other [acute care setting] sometimes struggle. (Adam: senior nurse: acute care)

Adam commented that a few years ago, the whole hospital seemed to run on agency staff but then the agency staff ceased being employed, and staffing was much better. There were, however, occasions when surgical operations were cancelled due to lack of staff, which he said was outwardly communicated as being '*no bed available*' he qualified this by stating, '*the bed is there, but there are no staff to complete the care*'. This statement seems intended to draw the public's attention away from the staffing levels and give the impression that there was no physical bed available. Indeed, this approach could be seen as a way of manipulating the public perception of safe staffing. Adam also drew attention to the publicising of staff numbers, which was a recommendation of the Francis report (2013).

Dawn

.

Dawn is a senior nurse in acute care and made the following observation:

It shouldn't be allowed that nurses work 12–14 hour shifts. I wouldn't want a nurse looking after me after she had worked 12½ hours. You can't recognise how tired you are. After 12 hours and you hadn't eaten, just some biscuits off the trolley. But I would be to blame for not delegating properly. (Dawn: senior nurse: acute care)

Dawn's text portrayed her worries about nurses' abilities and competence whilst completing long 12–14 hour shifts. She felt that these shift patterns were unsafe and could lead to errors in judgement. She alluded to the fact that after such a long period on duty the individual lacked the ability to know their limitations, saying: '*You can't recognise how tired you are*'. She also commented that there were insufficient refreshment breaks, leaving nurses to eat '*biscuits off the trolley*'. She brought in the stark reality of professional accountability saying, '*I would be to blame for not delegating properly*'. Again, the concept of blame appeared, and Dawn recognised that even if there were mitigating factors, such as exhaustion, poor nutrition, no comfort breaks and low staffing, the qualified nurse would remain accountable for her actions and omissions. She applied an empathetic and value judgement to her observations by making the following observation: '*I wouldn't want a nurse looking after me after she had worked 12½ hours*'.

Gemma

Gemma is a staff nurse in acute care and made the following comments about her present job and reflected upon her previous post in primary care.

Staffing levels here are good, mainly because it's a small unit, but in the [primary care service] it was awful. We were part of the [national service reorganisation] and we were moved from health to social care and the service was cut by 40%. But the workload remained the same. Lots of us left because the workload was unmanageable. They still wanted the same service to go ahead, with so few staff to run it. The budget was cut, but it wasn't positive... In one instance, we used to vaccinate [specific service users] in [location]. We had to give three vaccines per [specific service users], and we had a whole session to do. If it ran over, it would be a pain for all concerned. We complained about

it, but they said go as slow as you need to, but you were still expected to get it done. Mistakes do happen. It's devastating for everyone. The staff member, the [service user], their [families]. An incident form goes in. The staff member gets spoken to. They investigate. (Gemma: staff nurse: acute care).

Me: That sounds really difficult. Do you see practice being changed if incidents happen like you just described? Because really you have all highlighted a problem?

Gemma

No not really. Because the problem is always put back to nurses, never that the service needs to change.

Gemma described working in a primary care setting whilst it was under a major reorganisation. She noted the demands remained the same, but the staffing budget was reduced by 40% leading to a massive reduction in staff numbers. The outcome was that the remaining staff were compromised, and she observed that '*Lots of us left because the workload was unmanageable*'. Gemma had already gained prior knowledge through her experience of raising concerns that this was not a realistic alternative, and she chose to leave primary care. Her words the '*workload was unmanageable*' signified that she felt it was unsafe to continue practising in this environment, as her professional accountability was compromised. Gemma then described a situation in primary care when she ran vaccination sessions. She described the unmanageability of the situation and the pressure she felt under. She noted that concerns were raised, and the management appeared to give no constructive help, abdicating themselves from any responsibility by advising them '*to go as slow as you need*'. This advice, however, would have meant the session would over run and this would cause problems for the service users, families and of course the nurses, who would have to work over their shift period. She said that mistakes did occur and this was '*devastating for everyone*'. Gemma's text illustrates the unsupportive environment she worked in, and how the excessive demands impacted upon the nurses, service users and their families. Again, she illustrates the unsafe environment, which was not changed by the raising of concerns.

Caroline

Caroline is a newly qualified nurse who had observed staff shortages in her first post-registration position as a staff nurse in primary care. Following her training in a large teaching hospital in the north of England, she moved to a comparatively large teaching hospital in north-west England. These were her observations on the two sites in primary care:

It is a real shame as I loved the community in [location]. But it's just awful in [location]. It's so short staffed and it feels like the senior managers just don't care. It isn't them though that will lose their pin number if anything goes wrong...All the visits are allocated a set amount of time, perhaps 20 minutes to do a dressing. If I spend too long in that patient's house then I will be late for the next one, and so on. They say that mileage is built in, but it isn't. These patients which we visit are generally very elderly, they take time to answer the door, and they want to chat to you. They may not have seen anyone all day, or all week. They don't want you to rush in, and rush out. They need and deserve better. If a patient complained that you rushed in and didn't have time to listen to them, the senior managers would be asking why, but then they don't supply enough staff. It's absolutely appalling. Those senior managers in their ivory towers should come and do some proper nursing and see how it feels to be us.
(Caroline: newly qualified staff nurse)

Caroline spoke of the reality of getting her first job as a staff nurse in primary care. She was clearly shocked at the reality of short staffing and excessive workload demands. She felt unsupported by senior managers, who she felt were aware of the situation that staff were faced with but they '*just don't care*'. Caroline was acutely aware of her professional accountability when she mentioned her '*pin number*', and that her registration was being compromised by the lack of time she had to care for patients. She gave a description of how her time was allocated and monitored, which was in her opinion inadequate to meet the needs of her patients. She allowed us to see the challenges she was faced with in dealing with the older patients who were lonely and socially isolated. Caroline demonstrated her compassion in wanting to

make a difference to their lives by simply having a chat, and the importance of this to holistic nursing. Her words '*they need and deserve better*' speaks volumes about the care she wants to provide. She noted how she was in a 'no win' situation, as if she rushed then she would be held to account, but if she provided care holistically, then she could not meet another patient's need for care. Her frustration and anger towards the management was evident, and she clearly felt they were not empathetic to the needs of the staff. Caroline's text made me feel very sad, as she had so much compassion and empathy for patients yet ultimately felt that she could not stay in an environment that compromised her values and her professional accountability.

All the different texts portray the sadness and frustration caused through low staffing levels. There was notable anger at the situations each participant had experienced, and often a sense that the organisational management did not fully understand the situation and the risks to patients. Caroline used the imagery of '*ivory towers*' to portray how separate she felt the senior managers were from the staff, conceptualising that they are far removed from the clinical role of patient care. The use of this vocabulary seems to strengthen the division between clinical staff and senior managers and makes for a more divided organisational culture. There was also the issue of excessive workload demands that impinge upon the quality of care and the safety of patients. Mel and Caroline demonstrated how they used an *authentic* mode of *being-in-the-world* to make a decision to leave primary care because of this situation. I reflected upon the interviews and identified with the emotional and ethical struggles, which participants had dealt with. I thought about the complexity of *being* a nurse and the daily dilemmas which are present in the lifeworld. Instead, in *being* a nurse we look at the holistic needs, which may not be initially apparent and may take a keen eye and practised assessment skills to identify. But in *being* a nurse we see this extra duty as a non-negotiable professional construct. As the texts demonstrate, specific tasks had been delegated, which could possibly have been carried out in the designated time if they were solely task focused. Mel witnessed specific nurses working in this way. But for the participants, and I must bracket myself with them, holistic care was non-negotiable. It became a burden to walk away without giving the patient '*time to chat*' (Caroline) or '*to sort problems out*' (Mel) or '*to short change them, on the communication front*' (Marie). This ethical conflict was clearly visible through much of the texts and is symbolic of virtue ethics, where participants struggle with the kind of

person they are and the kind of person they want to be, yet are compromised by the constructs of reality (Meagher, 2011). This dichotomy between the *authentic* self and the need to comply with the *the-they* and adopt an *inauthentic* mode of *being* was clearly met with a degree of *angst* from participants.

Whilst I have been undertaking these interviews I have been struck by the sheer complexity of being truly involved with the nursing of patients, and in *being* a nurse. Reflecting upon the participant's texts, I hear them describing the need for a holistic approach, and in doing so making decisions which impact upon their own physical and emotional wellbeing. It would seem so much easier to adopt a task orientated approach, and indeed some do as Mel observes. But the participants can't take this easy option. I share these thoughts and decisions, empathising with these dilemmas and the bravery of their decisions allowing me to see the real compassion which is evident in *being* a nurse. The next essential concept shows another problematical situation for participants, as they share their views on the management process in their areas of clinical practice.

Essential Concept 7: Management with regard to *solicitude* in *being-in-the-world*

Introduction

This essential concept of management is viewed through the hermeneutic lens of *solicitude* and relates to the care structure. The issue of management and managerial support was a central concern for participants, and was mentioned in relation to culture, professional accountability and collegial relationships. The subject of management generated strong feelings from all the participants.

Essential Concept 7

One of the foundation stones in the creation and maintenance of quality care and a robust safety culture is stable and effective management and leadership within an organisation (Leonard and Frankel, 2012). Certainly, the concepts of management and leadership can be difficult to define and are seen differently by different people and

groups (Armstrong, 2016). Lopez (2014) refers to the fact that the terms 'management' and 'leadership' are often used interchangeably, despite their differences. Although I am wary of proposing definitions of management and leadership, since there are many, I feel clarity is necessary. The following definitions from Armstrong (2012) appear to give a reasonable summary of the concepts of leadership and management:

Leadership can be described as the ability to persuade others willingly to behave differently. It is the process of influencing people – getting them to do their best to achieve a desired result. It involves developing and communicating a vision for the future, motivating people and securing their engagement. (Armstrong, 2012:4)

Management is the process of making things happen. Managers define goals, determine and obtain the resources required to achieve the goals, allocate those resources to opportunities and planned activities and ensure that those activities take place as planned in order to achieve predetermined objectives. (Armstrong, 2012:24)

In making comparisons between the two, Birkinshaw (2010) comments that leadership concerns the way in which individuals are influenced to follow, as opposed to managers who motivate individuals to achieve designated goals. However, Kotter (1990) argues that leadership in organisations produce beneficial change, whilst managers are concerned with quantifiable results. Grossman and Valida (2013) assert that leadership is influenced by the situation, the culture and characteristics of the leader and the followers. Indeed, the World Health Organisation (2014:264) acknowledges the need for 'managers to be good leaders and good leaders to have management skills'. This brings up an important aspect, and perhaps relates to the expectations of participants in discussing the way in which they experience management, namely if they believe their managers should have leadership qualities. The terms 'manager' and 'management', as opposed to 'leader' or 'leadership' were used by participants when discussing this organisational issue, so I use the term management to ground these findings.

Heidegger's (1927/2010) philosophy can aid our understanding of management by applying the concept of *care*, *concern* and *solicitude* to view the process of management differently. Later in this section, following the experiences of participants, I discuss how Heidegger's (1927/2010) theories on *leaping-in* and *leaping-ahead* can add value to the debate on management. For Heidegger (1927/2010), his notions on *care* and *solicitude* are grounded in our *being-in-the-world*, and our interaction with others. Heidegger (1927/2010) views these concepts through the lens of *temporality* and *authenticity*, since the past, present and future has a bearing on their actions, affording *authenticity* and *inauthenticity* depending upon the path taken. The subject of management was an issue to many of the participants. These are some of the comments and observations made during the interviews.

Marie

Marie works in primary care and spoke about how nursing management had changed over the years, and how the current structure left her feeling there was remoteness to management. She made reference to the main communication channel being through email, which she infers is a detached way of conveying information to staff.

There used to be clear hierarchies. Very clear demarcation and the ward sister certainly ruled everything that went on in the ward and I think that had a lot of positives and a few negatives. And these days in the community, it might be different in hospital, I really don't know anyone beyond the band seven and we don't know what's going on because apart from the fact that they seem to change frequently and there are so many job titles now I really don't know any of the managers. It has become quite confusing who is in charge, more than that, they will change their titles and people change roles, it seemed to be changing all the time, so I really don't have any kind of relationship with anybody beyond band seven. I feel that the management is remote and indeed I coined the phrase "management by mouse" because there's more management and communication by email. You know, I think it would be a lot nicer for people to pick up the phone or even get out from behind their desks and come and see your face in the clinic. (Marie: senior nurse: primary care)

Marie referred to the contrast between the past and the present, which was reminiscent of her previous texts. She signalled that she felt it was better in the past because of the clarity in the hierarchical system, in so far as everyone was aware of the management personnel. She made the point that in the contemporary healthcare setting where she worked she felt the managers were detached and inaccessible, communicating via email as opposed to in person. The lack of personal relationships, to the point of not knowing who the management team were or their job titles, was a worrying element to effective management and as Marie observed, opened a divide between managers and clinical staff. She stated that clinical staff were devoid of information, and I conceive this to mean information of a strategic planning nature. Again, this makes staff feel undervalued and isolated, and does not appear to be in accordance with contemporary government policy. The idea of communication being by email, in her phrase '*management by mouse*' is another issue with relevance to staff morale and staff feeling unvalued. Marie's text details a negative portrayal of the management of staff, with her overarching concerns being the remoteness of managers.

Gemma

Gemma worked in a hospital setting but also appeared to experience a detached and remote style of management. She expressed her astonishment that managers did not address problems on wards that have poor reputations.

My immediate manager both in the community and here is always around. In the community you rarely saw the band seven or eight. The band eight you rarely ever saw. The senior manager here you don't see. You get information cascaded via email. If you don't go and look for it you never get to know it. The modern matron I have only seen once on International Nurses' Day. The information only comes so they can say they told you so.... The CQC inspection has occurred recently, and they made suggestions. There are good wards and bad wards. It is common knowledge which the good wards are. You wouldn't apply for a job on those bad wards. Staff apply who don't know how bad they are, or that is the only place with jobs. It is ridiculous that we all know which the

bad wards are, but they [the management] don't do anything about them.
(Gemma: staff nurse: acute care)

The opening sentences in Gemma's text presented a positive picture of her immediate managers, who were visible and accessible, and seem supportive of everyday problems. However, she went on to say she felt that the more senior managers were remote, and the main communication channel was via email. There was also the point that the information cascade was principally through email, which could lead to some staff being less informed if they had limited IT access. On this note Gemma seemed rather cynical, believing that she received information only to safeguard the managers, so presumably when anything went wrong there was an audit trail back to the recipient. Gemma was also critical as to why no action was taken against '*bad wards*'. I would interpret this to mean unpopular, perhaps understaffed wards and perhaps, a ward run by an unpopular ward manager. The term '*bad wards*' is used several times by different participants and the analogy is the same each time: all staff were aware of which wards were classed as '*bad*', but this went unaddressed by managers. Another participant, Dawn, also made mention of these concerns relating to wards that were considered '*bad*'. Her text follows:

Dawn

There are bad wards in the hospital; we all know which they are. It comes from the ward sisters and the environment never changes. New staff get jobs there, and they either don't stay long, or they conform to the ward culture. I can't understand why it's allowed to continue. They do rotate staff sometimes, but only when staffing is bad. There is a new [very senior manager], she is only quite young. I have met her once. The managers are visible at official events. Not on a daily basis. There are matrons walking about, but not further up.
(Dawn: senior nurse: acute care)

Dawn allowed some clarity about the '*bad*' wards and afforded an explanation as to why she felt it continued. She made reference to the idea of conformity, as certain staff allow themselves to be drawn into the culture, whilst the others left. Dawn's text is reflective of Heidegger's (1927/2010) theory of how individuals adopt an *inauthentic*

mode of *being* by imitating the norms of the environment when she commented '*they conform to the ward culture*'. She also observed that for others, '*they...don't stay long*', which is reflective of Heidegger's (1927/2010) theory of those individuals who adopt an *authentic* mode of *being*, and choose not to conform to the expectations of *the-they*. Dawn's perception of the senior management team was that she felt they were remote, only visible '*at official events*', which seems in direct conflict to the ideals of effective management. Dawn had previously commented upon her experience of being a junior staff nurse, when she was reported for not coping after she raised concerns relating to inadequate staffing. Although her previous text was used to explore the concept of bullying, her insights into poor management are equally relevant to this section.

Adam had clear ideas about management. He felt that a manager's ability had less to do with their qualifications and more to do with their interpersonal skills and experience. He made the following comments;

Adam:

People do management courses; they study at MBA but that doesn't make them good managers. They need people skills. People skills don't come from education sometimes, it comes from experience. Some senior managers in the hospital are well qualified, but have no experience of doing the job. They follow the papers, they follow the directions, but they can't manage people. They sometimes bring people in, but they don't understand... It's all money, money, money. That's the mantra now. When you ask for money for courses they say there is no money left. Where has all the money gone? They have not managed the budget, but who oversees it? Management is poor at managing the budget...there is never any money. (Adam: senior nurse: acute care)

Adam's comments illustrate the frustration he felt at not being able to access professional development courses because the money set aside to fund these courses has been used up, or as he insinuated not well budgeted, and not supervised. Perhaps inferring of a lack of transparency. Adam's choice of words, repeating the words '*money, money, money*' added effect to his text. He used the term '*mantra*' meaning that it was repeated constantly to ensure that all staff heard and understood the message being given. Adam noted the importance of managers possessing

interpersonal skills, and having the capacity to communicate well with staff, as well as understanding the complexities of the organisation. He observed that in the past, managers were recruited from outside the healthcare setting but their lack of understanding about the complexities of nursing had created problems. He also ventured that people skills are attributes that are derived from experience, not taught through academia. This was also a sentiment expressed by Jean in the next exemplar.

Jean

Jean commented that the private organisation where she has a part-time job was experiencing difficulties through a newly appointed management structure. She described the following situation:

They have brought in two new managers and neither has worked in that area before. The clinical lead just sits in an office, and the new sister has only been qualified a couple of years. Neither of them understand the unit or the staff. They have brought in new rotas, which people are struggling with. They don't listen, and good staff leave. Everyone has withdrawn their goodwill now. Others will leave, it's a shame. (Jean: multiple roles)

Me: *You say that the new managers don't listen. Has anyone raised these concerns?*

I think they just see it as people moaning. I think if they took the trouble to really hear what they have to say and look at how unhappy people have become. But they just seem uninterested. They obviously have their own agenda. (Jean: multiple roles)

Me: *Do you get involved with it all ?*

Well, I am only there part time now, and I am not sure how long that'll be for. If it directly affects me or the patients then I would. (Jean: multiple roles)

Jean's perspective was from a private healthcare organisation, not the NHS, but I chose to use the text as it mirrored that of the other participants. She talked of a restructure and the arrival of two new managers to the unit. She observed their lack of experience in the specific field, and of experience in nursing generally. She described their detachment from staff, and not listening to their difficulties. The result was that staff retention was impacted, and goodwill withdrawn. Goodwill seems an invaluable asset in any organisation, and perhaps its merit is undervalued by managers. In earlier texts and literature, it is noted how nurses give extra unpaid hours to their employer, much of which stems from goodwill.

Mel

Mel, a senior nurse in primary care had previous experience of being a senior manager, and in the next exemplar spoke about the negative issues that she faced in a previous role. I have moved this to the end of the section as it covers a different perspective as regards management, and allows a different picture, from an alternative standpoint;

The reason I wanted to be a nurse is because I'm interested in patient care, that's the bottom line that's why I don't want to be a manager again, because I do think you get compromised as a manager, there's too many competing pressures, and I think the patient is at the bottom of the pile and they get forgotten and, and the thing I don't miss about the job, I'll be honest with you, I was sitting in meeting after meeting after meeting, discussing things that never happened and never changed, with thousands of pounds worth of staff sat round the table, who'd forgotten about the patient, you, you'll always say, the patient at the centre, and you think, actually, you've not mentioned them once, and you know, this what you're talking about, actually isn't benefitting the patient at all, this is about the organisation, this is about budgets, it's about ticking boxes, it's about, you know, targets, so, that bit, I don't miss at all. (Mel: senior nurse: primary care)

Mel raised an important point that was also raised under the issue of ethical distress, when nurse managers feel the organisational demands competing with the demands

of clinical staff. Mel described the dilemma she experienced when organisational drivers were prioritised above patient care, a thought again reminiscent of the Mid Staffordshire inquiry (Francis, 2013). Mel spoke of time spent in meetings, whose focus were not on standards of patient care, and infers that money was being wasted at this level of management. I could relate to Mel's words and her thoughts on the *competing pressures*, when it is difficult to please any of the parties you are trying to serve. Mel reminds us throughout her texts that her central concern is always for her patients.

Heidegger's (1927/2010) philosophy can aid our understanding of management, using his concept of *care*, *concern* and *solicitude*. As detailed earlier, the concept of *solicitude* encompasses the two ways in which we demonstrate care for others, in *leaping-in* and *leaping-ahead*. Previously, I made these connections in relation to a nurse caring for a patient, where *leaps-in* (*Einspringen*) may occur when patients are dependent upon care being delivered, and *leaps-ahead* (*Vorausspringen*) when the nurse may facilitate rehabilitation, health promotion and the empowerment of patients. However, in this section I apply the same two concepts to management. On the one hand, using the approach of *leaping-in*, a manager may take over responsibility of a situation from another member of staff. Heidegger (1927/2010) sees this as putting oneself in another's position in order to deal with the problem. Alternatively, the manager may use *leaping-ahead* to empower individuals to fulfil their own potential and possibilities (Heidegger, 1927/2010).

However, Heidegger (1927/2010) adds a cautionary note to using either or a combination of both strategies, suggesting there can be positive and negative consequences. By this Heidegger (1927/2010) means that *leaping-in* can be viewed in positive terms, as an act of respite, for a manager to take over and get the job done for them in the short term, alleviating the present stress and allowing them time to think. Alternatively, *leaping-in* could be seen as dominating the staff member that could leave them feeling incompetent and inept. Likewise, in *leaping-ahead* the manager does not solve a specific problem but empowers the staff member to see future possibilities and is less concerned with the present. *Temporality* is an important factor in this discussion, as *leaping-in* combines the past and present and the imminence of

the situation or problem, whereas *leaping-ahead* is grounded in the future. The following passage from *Being and time* perhaps sums this up:

With regard to its positive modes, concern has two extreme possibilities. It can, so to speak, take the other's care away from him. Concern takes over what is to be taken care of for the other. The other is thus displaced, he steps back so that afterwards, when the matter has been attended to, he can take it over as something finished and available or disburden himself of it completely...In contrast to this, there is the possibility of a concern which does not so much 'leap-in' for the other as 'leap-ahead' of him in his existentiell potentiality-of-being, not in order to take care away from him, but rather to authentically give it back as such. (Heidegger 1927/2010:122)

Most importantly to this discussion, Heidegger (1927/2010:123) notes that *solicitude* is guided by *consideration* (*Rücksicht*) and *tolerance* (*Nachsicht*), but that *solicitude* does have the capacity to adopt deficient modes of inconsiderateness and intolerance, which can have negative influences upon the concern for others. I suggest that in utilising Heideggerian philosophy relating to *solicitude* there should be an awareness of the consequences of possible actions, as well as grounding its application in consideration and *tolerance* for others. I refer back to Heidegger's (1927/2010) thoughts on *care* and *solicitude* later in the discussion of findings, to reflect upon whether this philosophy can have a bearing upon the current management and leadership theories used in the NHS.

Essential Concept 8: Professional accountability in nursing

Introduction

The ideals, standards and values that nurses strive to uphold can be influenced and on occasions compromised by the historical, social and political contexts that are apparent. Despite these challenges, nurses display a resilience and desire to facilitate high quality patient care. In accordance with the aims of this study, I explore the issues that influence the individual and professional accountability of nurses and their impacts

upon nursing care. Although professional accountability is the holistic focus of the entire study, this section relates to the individual and personal meanings of this concept. I begin by discussing the nature of professional accountability to avoid any ambiguity and allow this most central concept to the thesis to be understood. I then explore how Heidegger's (1927/2010) philosophy can aid our understanding of the nature of *being* a nurse.

Essential Concept 8

Professional accountability in nursing is considered to be the very foundation of nursing practice. Literature, however, reveals no uniform agreement to the description or definition of professional accountability (Krautscheid, 2014). Indeed, an ethnographic study by the Royal College of Nursing (2004) observes that despite its common usage in policy, practice and nursing literature the concept is often misunderstood and ambiguous. The Nursing and Midwifery Council (NMC) charge all qualified nurses to be professionally accountable for their actions and omissions (NMC, 2015a), but fail to elaborate on this. Sorenson et al (2009) conceptualise accountability as multi-faceted, encompassing 'ethical, legal, and economic implications as well as implications for patient care' (Sorenson et al, 2009:874).

Professional accountability has been seen as a strategy for managing expectation, becoming synonymous with liability and assuming negative connotations. Willems and Van Dooren (2012) assert that professional accountability is about more than merely being held accountable. Milton (2008) explains that definitions of accountability are influenced by societal context and that accountability is 'viewed as an essential element in the global, public health arena' (Milton, 2008:300). Accountability also carries with it legal complexities. All nurses have legal accountability to the general public that is enforceable under criminal law. Under civil law, nurses are accountable to patients for negligence, trespass and civil wrongdoings. Furthermore, there is accountability to the regulatory body of the NMC for professional conduct, as well as accountability to the employer under employment law. All registered nurses and midwives must adhere to the NMC code of professional standards (NMC, 2015a) whilst also working within local and national NHS guidelines (NMC, 2015a). In addition, registered nurses have a legally binding employment contract with their employer that

may also add specific employment and role requirements. In return, employer organisations have a duty to support staff to uphold the NMC code of conduct, as well as legal requirements to provide quality and safety standards for staff and service users (NMC, 2015a).

For Heidegger (1927/2010), accountability and responsibility are interesting concepts. Heidegger (1927/2010) believes that accountability lies only in the notion of free will and causality. Whereas, responsibility exists under the tenet of *self-responsibility*, since *Dasein* must have a concern for *being*, demonstrating responsibility towards oneself and of oneself (Heidegger, 1927/2010). Furthermore, responsibility can be viewed as a response to an occurrence, as when we hear the *call of conscience*, a silent call from *Dasein* to itself, we construct a response. As such, *self-responsibility* can come to mean the essence of the person and can be seen as determining our actions. It is, of course, the *call of conscience* that brings *Dasein* back from *the-they*, and the *they-self* to *authenticity*.

The ideals of professional accountability are conceptualised within the NMC code of professional standards (NMC, 2015a). Adverse media reporting on healthcare failings have brought a negative spotlight to bear on the nursing profession, and public trust has undoubtedly been damaged (Girvin et al, 2016). However, the personal aspirations of individual nurses continue to be rooted in the desire to deliver safe, high quality care to patients. I would argue that nurses want the profession to be respected and inspiring to future generations. In this section I explore the participants' perceptions and experience of professional accountability, and in doing so, their feelings of *being* a nurse, and how they cope with the complex pressures, competing priorities and general *everydayness*. Each participant was asked what professional accountability meant to them, and how they thought it affected them in their day-to-day working. Their responses are presented below:

Caroline

Professional accountability [pause]. Well I think it's about my responsibilities, and who I am accountable to as a professional. [Pause] erm well, I know I have a duty of care to the NMC and to my patients, to make sure that I give the very

best care to them that I can. I think that the NHS has an accountability to the patients too, to make sure that nurses are properly trained and can give the correct care. I am responsible to them as well. I would always try and do the best for people. I always want patients to think, "She was nice, I hope she looks after me again". I see other nurses not being, well, as good as they could be, you know not giving 100% and I don't ever want to be them. I don't mean they are doing things wrong, but not as good as they could. But there are some that I would [emphasis on would] want looking after me, or my Mum, or my Nan. I know it's hard, and things aren't right, like with enough staff. But you've got to do your best. I think we should have more time. [Pause] Well, fewer patients so that you can give them what they need. Does that all make sense? (Caroline: newly qualified staff nurse)

Caroline's text conveyed the heart-warming description of what professional accountability means to her. As a newly qualified nurse, she provided a glimpse into what it feels like *to be* a new nurse. She compared herself to more experienced nurses and offered a brief description of two opposite characteristics. The nurse who is giving less than they could and the one that she sees as a role model, someone she would want looking after her and her loved ones. Caroline's descriptions were steeped in emotional context and described the emotional labour present in nursing. Later, she followed up on her earlier comment on having more time to nurse, which seems to represent a major issue in her practice. Caroline's text summed up what professional accountability means on a personal level, about giving the best possible care that one can. The text does not use organisational terminology such as effective, efficient, quality or safety, but by her own use of language she sums up a clear perspective of nursing and the art of caring. When talking with Caroline, she was bubbly and enthusiastic about nursing. She epitomised the joy of nursing and displayed an ethical sensibility in her understanding of the value of kindness and caring.

Jean

Well, professional accountability means you are accountable to your patients, your organisation and to the NMC. I am always aware, and I document everything. I always think it could be used in a court of law...If I had my time

again, I'd still choose nursing. It's been a very rewarding career for me. I love the feeling that I've made a difference, whether that's on the phone giving advice or in the surgery helping someone with [specific medical condition]. Every day is different and although there is never enough time in a day, but I do enjoy it. (Jean: various roles)

Jean was very factual in her response, detailing the three areas of accountability. She then took a legal perspective, highlighting the importance of maintaining good record keeping, to evidence all the care she has given. In many ways it is devoid of all emotion, unlike Caroline's text. But it does show that Jean is being realistic and careful, protecting herself from any litigation. Perhaps this close regard for her professional regulation is systemic from being involved in a blame culture, when one's first thought is to keep oneself safe from harm in a legal sense. However, Jean then made a decisive statement about her love of nursing, reflecting upon the point that if she had to relive her life, she would repeat her decision to enter the nursing profession. This was a powerful way to describe the passion she felt for nursing. There was again a sense of realism, as she acknowledged the time pressures that she encountered, whilst evaluating her fulfilment with her various nursing roles.

Marie

I think sometimes we pay lip service to this, and my experience of it is that the nurses that I worked with do the best for the patients under the circumstances, and so I think that they are working to the NMC guidelines. Your first accountability is always to the patient and the public. You have accountability to your colleagues and also to your organisation. But then the organisation has an accountability to you and I think probably I think you just get the impression it's a paper exercise for them when at the end of the day it doesn't matter what they are doing. You know the people at the coalface are the ones who are endeavouring to deliver you know the highest, the highest quality care they can deliver to everybody that needs the service and often to those that don't... The Chief Nurse, I think that's her title, who said that about the 6Cs, either has a poor view about nurses or nursing is in a poor state. (Marie: senior nurse: primary care)

In the first exemplar, Marie's opening statement was an observation that professional accountability had become empty rhetoric, saying, '*we pay lip service to this*', meaning it can be an empty phrase, which is not backed up by the employing organisation. Her sentiments carried the stark reality that nurses are trying their best with insufficient resources. She later reinforced her opinion that nurses are committed to delivering the highest quality of care even in the most challenging of circumstances. She used the word '*highest*' twice to reiterate the point. Marie also made mention of having accountability to one's colleagues, which stresses the high value she relates to collegiality.

In her second exemplar, Marie brought up the issue of the Chief Nursing Officer's declaration that every nurse should demonstrate the '6Cs' (Cummings, 2013). She sees this as being interpreted in two ways: either there is a negative view about individual nurses or the nursing profession as a whole is in crisis. Marie appeared quite disconcerted as she spoke, signalling her disapproval that nurses needed to be reproached so publicly by the highest ranked nurse in the UK. The 6Cs relate to the six fundamental values in nursing: care, compassion, competence, communication, courage and commitment (Cummings, 2013). In her earlier texts, Marie demonstrated her frustration and sadness in not being able to practise nursing in the way she felt she should, because of limited resources. Using the hermeneutic circle I can more clearly see how Marie's comments concerning the state of nursing is linked to the wider debate on public spending on the NHS. The issue of the 6Cs was also mentioned by Dawn and Gemma.

Dawn

I am accountable to almost everyone, to your patients, your colleagues, your managers, to the doctors, to your trust. As a nurse you are the front line of care. You just do your best. The 6Cs come into this. If you have the right support it shows. With everything that is happening. You get short staffed, if people ring in sick. In [location] we once ran out of gloves. If you have good support you can do your best. You cannot always control everything. I hope the Trust would

back me, but I am with the [union] just in case [laughs]. Someone once told me that you need a backup plan. They [union] supported them. I have learnt that you need to report everything; you need to write everything down. When I was new to the Trust I was left in charge. I called the bed manager. I put my thick accent on, and said come on help me out. They gave me someone to special a patient. (Dawn: senior nurse: acute care)

Dawn commented that she was accountable to her patients, colleagues, managers, doctors and the employing trust. She described nursing as doing your best, often in situations that you have no control over. She makes mention of when nursing in her country of birth there were no gloves available, but she still managed to carry on. Like Jean, she pointed to the need for adequate record keeping, to safeguard herself, if things went wrong. She also described having to accentuate her foreign accent to gain some help when she was new and left in charge. Dawn also felt she was accountable to her colleagues, again reinforcing the importance of collegiality. She also mentioned accountability to the doctors, which may be a stance relating back to her country of birth where doctors were involved with nurses' regulatory processes. It may also be connected to her nursing status, working closely with medics in acute care. Dawn highlighted the fact that in her opinion, whatever the circumstances, nurses did their best and gave of themselves to patients.

In a second exemplar, Dawn discussed an interesting concept, that of *potentiality*. She commented upon the fact that nurses did not always fulfil their *potentiality*, choosing to remain in the same role for their entire career. In the following text she explains her observations:

We have different gears in nursing, the band five lowest rank ones, the specialist ones, the management ones. All different gears. Sometimes you have aspirations, but you work as your peers do. Some band fives will always stay as band fives, while some will aspire and work their way up. These gears in nursing are very interesting, looking at how people behave. (Dawn: senior nurse: acute care)

Dawn's text is a good reflection upon Heidegger's (1927/2010) theory of the *care* structure, and her observations demonstrate how some people will conform and imitate others. She acknowledged that sometimes aspirations were dismissed in order to conform to those around you, and as a means of fitting in. McLeod (2016) considers conformity to be a type of social influence, which involves the individual changing or modifying their behaviour in order to yield to the established norm or group pressure. In Heideggerian (1927/2010) terms, this fleeing from our possibilities represents an *inauthentic* mode of *being*. Of course, it could equally be said that many individuals make a conscious decision to remain in band five roles, and it would be inappropriate to infer they have not realised their possibilities, as this would be judgemental and incorrect. Indeed, Heidegger (1927/2010) says of the *care* structure that we must ask ourselves what is our own *potentiality* and strive for that ideal. The point is not to accept *being* in a situation purely to conform to others and imitate what others do. In order to achieve *authenticity*, we must realise our possibilities. Dawn observed that certain individuals do, however, fulfil their possibilities and develop themselves as specialists or managers. I did not interpret Dawn's analogy as being judgemental or negative, and when combined with Heideggerian philosophy, it provided a good representation of the *care* structure, which is simply the way individuals interact with the world. The essential concept of *care* can be used to drive our ambitions, to allow us to seek *authenticity*, by allowing a transformational career progression into diverse and exciting career prospects. In my own nursing career, I have always been motivated to pursue academic and clinical advancement, finding this to be a great motivator. However, there have been many times when I have met barriers from other nurses, who have been critical of nurses wanting post graduate qualification. At the commencement of this PhD I struggled to gain funding from the NHS, and I was told by a senior manager that a PhD was unnecessary for nurses. If nursing is to become a stronger profession, with a voice that is more publicly audible, then it would be reasonable to assume that its strength must come from within its own body, with nurses nurturing colleagues, as oppose to limiting their success.

Mel

Well my professional accountability. [Pause] Well what I would say is, it's two, it's two pronged really, I'm accountable to the Nursing and Midwifery Council,

because I'm registered with them, so to maintain clinical standards of practice, but I'm also accountable to the people I serve. [Pause] Erm, well, [pause]. I know this will sound really bad, but, yes I'm accountable to the organisation within the job role I'm given with my job description, but, I'm more interested in patients, and maintaining professional standards, so that's where my accountability lies. Yes, I've got to work within boundaries. Yes I've got to, you know, I can't work outside of my job description, and I can't go around shouting at people, managers in the organisation saying they're all idiots, can I? [Laughs] Even though that's what I think, but, it's working within boundaries, in a safe, you know, in a safe way. (Mel: senior nurse: primary care)

Mel was at times hesitant within the text. She seemed to hold back, seemingly wondering how much information she should impart to me. She does, however, sum up the three areas of accountability, even though she first voices that there are only 'two prongs' to it. She also makes an apology saying, '*I know this will sound really bad*', as if she should not be commenting upon the professional accountability to the organisation. Mel seems to be referring to accountability in relation to employment law, as opposed to the professional accountability to oneself and the regulatory body. Following some reflection upon my part, I wonder if she saw her accountability to the organisation as in conflict with her professional accountability to the NMC and herself as regards the issue of resource allocation, when her own ideals were compromised. Mel voiced a lack of respect for the senior managers by referring to them as '*idiots*', although she admitted she would not publicly have said that. The lack of respect would also explain her reticence in attributing her professional accountability to the organisation, which she sees as being represented by the managers. In Heideggerian terms, Mel displays her *authentic* mode of *being* by distancing herself from *the-they*, and wishing to be viewed as separate from them. She is aware of her boundaries and the rules she must conform to inauthentically, but also her own strength, which she uses to concentrate upon her accountability to her patients.

Gemma

What do you mean my professional accountability? Do you mean who am I accountable to? [Pause] Well I am accountable to my patients, the Health

Authority, the NMC and to my conscience I suppose...Nursing has changed because people used to view nurses as kind and caring. They are now viewed with suspicion. People's expectations have changed, they expect more. ... The NHS is trying to get rid of the person behind the role. The best part of the job for me is the patient. But they don't want you to interact the same. In the community when you got people to trust you it was fabulous and so rewarding. I do things like touch them [indicates her hand on top of her other hand]; they say it's not PC to be friendly. I am not allowed to call people love or refer to them by their Christian names. Student nurses say we were told to say Mr or Mrs "such a body", but to me that can be cold and to me disrespectful. I want to be warm and see people's humanity. I want to show compassion and kindness, and it is such a shame that by showing patients that I care others think that I am unprofessional. I would want a nurse looking after me to hold my hand if I was upset or frightened. That is being a nurse. They want to take away the person from behind the nurse. They speak about the 6Cs but I know what it means to nurse and be a nurse. (Gemma: staff nurse: acute care)

Gemma was initially hesitant, confirming that she had understood the question correctly. She gave a moment's pause before answering the question, and then a short, but succinct response concerning professional accountability. She cited her accountability firstly to her patients, then the organisation and lastly the NMC, then added accountability to her conscience. It is interesting she used the word conscience as opposed to the word myself. The use of the word *conscience* generally describes our moral set of values, a guide to what is right and wrong, ethical or unethical. For Heidegger (1927/2010) it denotes *Dasein's* silent calling to itself.

Gemma's text articulated how she feels nursing has changed. Her viewpoint almost contradicts the Chief Nursing Officer's message, which urges nurses to show compassion (Cummings, 2013). In contrast, Gemma felt that there was a pressure upon her to mask her compassion in favour of appearing more professional. Gemma commented:

I want to be warm and see people's humanity. I want to show compassion and kindness, and it is such a shame that by showing patients that I care others think that I am unprofessional.

There was an inference in Gemma's text that nursing is losing its uniqueness and caring by striving to be a profession. Gemma noted that her display of emotions towards patients had been negatively perceived by her students. There appeared to be a genuine sadness that she should not display emotion whilst delivering nursing care. For Gemma, there was a clear conflict between the call for nurses to show compassion and the message to regulate behaviour by suppressing one's emotions in line with the organisational norms. Heidegger (1927/2010) speaks often about understanding (*Verstehen*) when *Dasein* experiences an 'openness to the world', combining the idea of possibilities and projection into the future. Heidegger (1927/2010) sees understanding as two-fold, as an understanding towards the world and toward the self, that is, *Dasein*. Put another way, Heidegger (1927/2010) sees this as looking for the meaning and understanding of beings and of *being*. Gemma felt she should show her emotion when caring for patients, as she felt that demonstrated her ideas about compassion. Heidegger (1927/2010) encourages this *discourse*, as an opportunity to think and make sense of the presenting situation, and in a broad sense, make sense of our world and our *being*. Again this tracks back to turning to our *authentic* self. Gemma was quite assertive when she talked about what she considered to be the correct way to behave. She made me aware that her behaviour towards patients had been questioned, reflected upon and appraised, but she had come through this process with a sense of her *authentic* self. Although this may mean she will be against *the-they*, she feels it is right for her. Heidegger (1927/2010) discusses the importance and significance of other people's influence as the concept that unites all existentials, since it forms the basis of the other existentials.

Heidegger (1927/2010) also has an important viewpoint on emotion and mood, which can be applied to the emotional labour required in nursing. His concept of *Befindlichkeit*, a term denoting attunement, refers to our moods. Heidegger (1927/2010:134) explains that in order to investigate *Dasein's being-in-the-world* it is necessary to look at 'the existential constitution of the-there', alongside 'the everyday being of the-there', taking account of attunement (*Befindlichkeit*) and understanding

(*Versehen*). To clarify this, *Dasein* finds itself *in-the-world* through *thrownness*, which is experienced through one mood or another, never indifferently. If I were depressed, then the world is disclosed as a miserable and dark place, whereas if I am in a happy mood, the world appears bright and full of wonder. Heidegger (1927/2010:137) argues, however, that a mood ‘comes neither from “outside” nor from “inside”, but arises out of *being-in-the-world*, as a way of such being’. Dreyfus (1991) points out that our moods can highlight what really matters to us. It is also important for the discussion of emotional labour in nursing, that I bring in Heidegger’s (1927/2010) thoughts on the world-disclosing moods, which assert that there is an element of cultural conditioning in our moods. This theory builds upon *Dasein*’s possibilities and the fact that we have the freedom to make choices regarding our *authenticity*, which are influenced by the societal norms of our *lifeworld*.

Applying these Heideggerian concepts to the data, I can see that Gemma was experiencing some distress, borne out of frustration and sadness at her interpretation of the cultural norms of presenting a ‘professional face’, against her beliefs of presenting an ‘emotional, and compassionate face’ of nursing. Gemma’s viewpoint went a step further, by suggesting that ‘*they want to take away the person from behind the nurse*’, implying that nurses should be unemotional and display a more ‘professional’ front, indicative of Heidegger’s (1927/2010) thoughts on *the-they* and the cultural conditioning that asserts itself onto *Dasein*’s *being*.

Adam

Adam took a different stance in describing what professional accountability meant to him:

I always have to keep very accurate notes. My notes are looked at by the doctors. I have to be very specific, write down if I am following certain [specific medical role] directions. Some [specific medical role] want [specific clinical procedure] and others want [specific clinical procedure]. I have to record everything that I do. I am always accountable to the [specific medical role]. If anything goes wrong with a patient they would come and see me, my line manager would come and see me. They would look at my notes. We would use

this to change our practice. There are [number of staff] of us, we are all very experienced. (Adam: senior nurse: acute care)

Adam launched into a lengthy description of how he was professionally accountable for his clinical practice, imparting specific knowledge relating to his role. For this reason it was not deemed suitable to display some areas of his text, as this may allow his identity to be uncovered through his detailed descriptions of his clinical practice. The exemplar that is presented, however, denotes how Adam safeguarded his own professional accountability by ensuring his notes accurately reflect all his clinical interventions. He mentioned the importance of documenting the specific instructions he had been given by medical staff. Adam's text signifies the necessity of accurate notes, and highlights the fact that record keeping is the evidence behind any nursing activity.

In a society that is becoming more concerned with litigation, it has received a more elevated position in healthcare. I recall the often-used phrase in nursing 'if it isn't written down, then it hasn't been done', which is common sense advice, and critical in clinical practice. Documentation audit, and the threat of notes being scrutinised in a Coroners Court can add to the perception of a blame culture. Unfortunately, however, the reality of the situation is that after the passage of time, notes are the only evidence of that care being delivered. I have been in the situation where my own nursing records were called by the Coroner to investigate the death of a patient at the end of life. The patient's spouse had complained that end of life medication had expedited the patient's death. I will remain forever thankful that I had made the time to articulate all of my actions, my advice, my explanations about medication and the medication administered very clearly and concisely, in accordance with the protocols. It did not, however, extinguish my anxiety in the weeks before the case was to be heard, but at least my records demonstrated my competence and decision-making processes.

This essential concept looked at professional accountability and the committed aspirations of individual nurses to deliver quality care. The most audible messages coming from the texts are that despite all the challenges they have faced, participants had an overriding desire to care for patients in the best way they could. All the participants discussed the caring aspect of nursing, and the way in which emotional

care is given to their patients. This empathetic approach of putting oneself into a patient's position and trying to imagine how they are feeling can be described in Heideggerian terms by Gadamer (1975/1996) as a 'fusion of horizons' between the nurse and patient. Thus, the *being-in-the-world* of the nurse unifies with the *being-in-the-world* of the patient, creating a close nurse-patient relationship, demonstrating a commonality of *being*. This is a very important point and raises one of Heidegger's (1927/2010) central beliefs that our *being-in-the-world* is unique, which is to say that our *Dasein* is unique and always personal to the self. The world, as we experience it, is unique, and yet for all the differences that exist, there is also a commonality in our everyday experiences that unites people in the world.

From a Heideggerian (1927/2010) perspective, the commitment and aspirations that are apparent in the participants' texts, and more broadly speaking in nursing generally, can be seen through the lens of hope. Heidegger (1927/2010) views hope as fulfilling one's own potential, hoping for something that is good for oneself, and for one's concern for others. Again, this brings in the concept of *solicitude* and concern for others. In the care structure, Heidegger (1927/2010) discusses the *facticity* of *thrownness*, and makes the point that we can change our thrown situation and embrace our future *potentiality*. Heidegger (1927/2010) calls this *projection* (Entwurf), a concept that he later calls *freedom*, whereby we adopt an *authentic* mode of *being*. This new *understanding* or *Verstehen*, is a way of seeing things differently, or making sense of things, and allows *Dasein* to disclose itself through its *possibilities* (Heidegger, 1927/2010).

Chapter Seven: Discussion

Overview

This chapter commences with a review of the study's aims before discussing the key messages that this study offers to the nursing profession. Following this will be a broader discussion of the issues highlighted which incorporates the available literature and the philosophy of Heidegger (1927/2010). This discussion chapter will integrate the essential concepts which emerged from the interviews, and these will be arranged in broader contextual headings, to ground these findings. These new headings will be culture, management; professional accountability; the emotional costs of nursing; and resilience. In this way I hope to demonstrate how my findings fit in with other scholarly work and elucidate how this thesis may offer new insights with regard to contemporary nursing research.

A review of the aims of this study

A reminder of the aims of this study is worthwhile at this stage, to allow the reader an opportunity to recall the purpose of this exploration of the nurses' *lifeworld*, in respect of professional accountability. In reflecting upon what has been found through the data analysis process, with reference to the study's aims, new insights are uncovered, that bridge understanding into this next section. The aims of this study are as follows:

- To explore the perceptions and insights of nurses' experience in terms of their own professional accountability whilst working in the NHS.
- To explore factors that influence nursing practice and individual accountability.
- To explore the impacts of nurses' professional accountability on patient care.
- To add to the existing body of knowledge and develop insights to inform future practice, thinking, research and education.

Introduction

This study has explored the participants' *lifeworld* and issues around their professional accountability and the effects upon patient care. The presented texts in chapter six reflected participants' perceptions of the culture of the NHS, and the factors and

contexts that impacted upon their professional accountability. The exemplars selected, have demonstrated the emotions which participants felt and the complex challenges that were apparent in their everyday work. Using the philosophy of Heidegger (1927/2010), I have endeavoured to present a balanced and honest interpretation of participants' experiences, and make my interpretations visible, by discussing my pre-understandings, personal experiences and changing perspectives. I acknowledge that others may interpret the text differently. The essential concepts that emerged from the data were; culture, fear, self-protection, positive and negative collegial relationships, care and solicitude in nursing, and its effects on nursing care, management in nursing, and professional accountability in nursing. Participants demonstrated their passion for delivering high quality nursing care juxtaposed with their disillusionment with nursing as a whole. Anger and frustration was evident in the texts as participants spoke about trying to bring about change, in often unsafe working environments when staffing was poor and workloads excessive. They spoke about management being remote, inaccessible and blaming. Yet there was a strong message concerning the strength and resilience which came from colleague support and the need for a safe dwelling place.

The key messages which this study delivers, based upon my interpretations, are the need to change the culture of nursing, and to build upon the current good cultural practices that do exist in nursing. A value-based management and leadership approach should be nurtured to establish a positive environment where nurses feel safe, supported and empowered. A reformed approach to governance is required, which values front-line staff opinion and motivates them to achieve good practice. Governance policy also needs to establish an effective reporting system, which encourages openness and transparency, by changing systems as oppose to blaming individuals for individual mistakes and system failures. Staff need support, through professional supervision, which is prioritised and regularly available to all NHS staff, and facilitated by trained individuals. To establish a positive culture this study recommends that areas of existing good practice be built upon, such as communities of practice, whereby research is integrated into clinical areas, fostering collaborative working and valuing of expertise.

Previous studies have focussed on specific cultural problems such as nursing incivility or collegiality, or in nurses' behaviours or stresses, or more generally, in student nurse experience. This study however, takes a Hermeneutical approach to explore professional accountability as a holistic concept using the philosophy of Heidegger. This work adds to the body of literature in a unique way, by looking at how nurses experience professional accountability in nursing and the factors which compromise it. The philosophical underpinning of this study illuminates a new perspective of the nurse's lifeworld in relation to professional accountability. This has a fundamental importance in understanding nurse's being-in-the-world, and the external elements which affect it.

Contextual Headings used in this Discussion

The aim of this discussion is to highlight the key contribution which this study makes to the existing body of knowledge. In doing so I will highlight the similarities and differences to the extant research relating to accountability. The philosophy of Heidegger (1927/2010) can also add value to this discussion, and many of his theories will be interwoven into this Chapter. My intention is to take a positive perspective, to look at the issues that have become apparent, and the possible solutions required to remedy the current situation. In order to ground the *essential concepts* into the wider context of nursing, I adopted the new headings of culture; management; professional accountability; the emotional costs of nursing; and resilience. By applying these new headings I was able to demonstrate how my findings could be applied more generally to nursing, and in this way could be more solution focussed in my approach to recommendations. This new direction was formulated by a process of trial and error, as I initially used the essential concepts as headings in the discussion, but this generated considerable repetition. On reflection, I feel the new headings have allowed me a greater freedom of discussion and has afforded a greater interaction with the literature.

Culture

The findings from this study present a narrative of what it is like being a nurse in the National Health Service in the United Kingdom in relation to their professional accountability. The participants described a negative culture which was fuelled by blame, and of the consequential anxiety which this environment produced. The findings also depicted a hierarchical culture, which was perfused with rules and protocols, which governed the individual, and added to the sense of division between front line staff and managers. Examples of these findings are particularly seen in the texts of Dawn, Gemma, Marie and Mel. The interviews clearly articulate how the blame culture is present, and the negative opinions of how their clinical practice is affected by the organisational structure which is in place. The adjectives that are used by participants to describe this phenomenon are *crucified*, *blamed*, and *punished*, which are extremely negative terms, and encouraged me to reflect upon the culture of the clinical environment. I held the belief that the culture should be grounded in compassion, but this was not the case from the participant's experience, and in reality, not in mine. In Gemma's interview, the connotations around incident occurrence, was that it sought to punish and blame individuals as opposed to the utilisation of reflection and learning. Indeed, the literature, supports these findings, as a study by Burkoski (2007) also found that the perceived behaviour of organisational leadership in apportioning blame to individuals was a major barrier in staff raising concerns, and in the case of Gemma's text, she articulates her decision to use a self-protective approach in future, should concerns present. Moreover, Khatri et al (2009) identified the existence of blame cultures in organisations which were generally hierarchical and risk averse, adopting a compliance-based approach to management. The consequences of a blame culture are that staff are reluctant to engage in incident reporting, as could be seen in Gemma's observations. The result of such reluctance to raise concerns creates a lack of transparency and openness in healthcare practice (Waring, 2005; Berwick, 2013; Kirkup, 2015).

The notion of addressing the existence of a blame culture in the NHS is not new. Indeed, Reason (1997) studied the no blame culture two decades ago, and his work was utilised initially to engage practitioners in risk planning, but has over time become little more than rhetoric. The following quote sums up his arguments;

"A no blame culture is neither feasible nor desirable A blanket amnesty on all unsafe acts would lack credibility and oppose natural justice.... A just culture an atmosphere of trust in which people are encouraged, even rewarded for providing essential safety related information but in which they are also clear about where the line must be drawn between acceptable and unacceptable behaviour". (Reason, 1997: 195)

This study's findings in relation to how participants visualised the nursing culture as one of blame in relation to incident reporting, was particularly poignant in Caroline's text, where she describes how she witnessed colleagues being held accountable for mistakes. Her depiction infers the anxiety of the situation, as she notes the system failures which had not been addressed, against the severity of their punishment. The findings from this study intersect with many historical and contemporary government reports and is noted in government policies that have sought to address the situation of a blame culture within the NHS. In 2004 The National Patient Safety Agency devised an incident decision tree (NPSA, 2004) to assist NHS managers to change from attributing blame to finding the cause when errors occur. The goal was to encourage openness and transparency by applying the same fair and consistent approach to each incident that occurred. This was followed in 2006 by seven steps to patient safety for primary care (NPSA, 2006) which offered a guide to best practice. Vincent (2010) asserts that in order to better manage the culture of the NHS we have to create a 'safety culture' that has a universal understanding which is shared by all its members to ensure positive and common values. Vincent (2010) goes on to observe that there must be shared learning to cope with challenges of 'external adaptation and internal integration', with an ongoing commitment to teach new members the correct way to think, act and behave. The vision conceptualised by Vincent (2010) was founded upon the behaviours of caring, commitment and compassion.

Robert Francis QC (Francis, 2013) cites Vincent's (2010) work in his conceptualisation of culture and the challenges of developing a positive culture within a large and diverse organisation such as the NHS. The following quotation describes his perceptions of the culture of the NHS:

Aspects of a negative culture have emerged at all levels of the NHS system. These include: a lack of consideration of risks to patients, defensiveness, looking inwards not outwards, secrecy, misplaced assumptions of trust, acceptance of poor standards and, above all, a failure to put the patient first in everything done. The emergence of such attitudes in otherwise caring and conscientious people may be a mechanism to cope with immense difficulties and challenges thrown up by their working lives. (Francis, 2013:1357)

In the quotation above, from the Francis report (2013) and with reference to the failures in healthcare made in Chapter Two (see Table 2), there has been many assertions about the culture of nursing, and the presiding culture of the NHS. The Francis report (2013), reported upon the existence of poor standards of patient care, and the prevailing attitude of nurses who did not care, and lacked compassion. However, an important issue that was raised by participants in this study suggested that there exists an ineffective reporting system in the NHS. Participants observed that their concerns regarding the clinical practice environment were frequently ignored, with no changes apparent. As Gemma and Dawn described, the raising of concerns was met by performance management techniques, which served to silence them. This study also found that nurses' professional accountability is compromised by inadequate staffing making it difficult to meet the demands of patients with complex needs. Mel's text is particularly reflective of this, as she voices her concerns and frustrations in relation to the limited resource availability. There is also an element of de-sensitivity to the environment which is shown in Marie's text and this idea is mirrored by a corpus of nursing studies relating to socialisation, such as Greenwood (1993) and, more recently, Traynor and Buus (2016). Mackintosh (2006) adds that for many nurses, emotional desensitisation was a means of allowing them to cope in complex and often distressing nursing situations. Evidence from the literature concurs with the findings of this study, demonstrating that professional ideals may be lessened or even lost by professional socialisation in nursing as they encounter the often challenging milieu of clinical practice. The cynicism of experienced nurses was also evident in the text of Caroline and Dawn as they relate their distress and anxiety in specific situations.

Participants in this study articulated a need for a culture which valued and protected them as nurses. Adam speaks of the token gestures that he had seen earlier in his

career, which made him feel appreciated. Dawn and Mel speak of the value they attach to the support of their peers and line managers. The need for a safe and supportive environment is highlighted in situations where participants have experienced discomfort. In the text of Caroline, the absence of a sense of belonging motivates her to leave the practice area. The benefits of a supportive culture within health care organisations is evidenced in the literature. A study by Twigg and McCullough (2014) posit that a positive practice environment increases the standard of patient care and improves nurse retention, findings which concur with Clarke and Aiken (2008). The concept of *being* in a supportive or positive environment links well to Heidegger's (1954/1993) notion of dwelling. Heidegger (1954/1993) makes *dwelling* a central theme in his later writings and uses the term to describe the way that *Dasein* is in the world. He describes *dwelling* in the sense of belonging, being in a familiar and safe place, not just in a physical sense, but in an emotional sense. It can therefore be argued that in *dwelling*, *Dasein* is in a safe setting surrounded by cultural practices that are familiar, a situation which Heidegger (1954/1993) refers to as *Being as appropriation*. In this context we can recognise through Heidegger's (1954/1993) work the importance of being in a safe and supportive environment, which nurtures development. It is also worth noting that Heidegger (1954/1993) refers to the fact that in *dwelling* one is in a setting of known and familiar practice, reminiscent of *zuhanden* coping, which allows us a fluidity and transparent mode of *being*.

Throughout the study participants articulated the anger and frustration at not being able to complete the standard of care that they wanted to, due to the constraints of time and staffing. Marie describes the ongoing problems of low staffing, and the coping mechanisms employed by staff as they are constantly faced with limited resources. The recognition of participants' inability to provide holistic care is reflected in the seminal work of van Maanen and Schein's (1977) *theory of organisational socialisation* which demonstrates that members of an organisation adapt and find ways to cope with the constant problems which they are forced to live with. The following statement conceptualises this theory;

'Such cultural forms are so rooted in the recurrent problems and common experiences of the membership in an organisational segment that once learned they become viewed by insiders as perfectly "natural" responses to the world

of work they inhabit. This is merely to say that organisational cultures arise and are maintained as a way of coping with and making sense of a given problematic environment.' (Van Maanen and Schein, 1977:2)

Houghton (2014) posits that the theory of organisational socialisation begins when an individual starts a new job or changes their role within an organisation. Metaphorically, just as scientists would see the use of genetics to ensure the survival of species, so organisations ensure their own survival. New members although bringing new ideas and values, have an overwhelming desire to fit in with existing members. The sense of belonging allows new members to build more positive relationships, and in relation to student nurses allows them more effective learning (Houghton et al. 2013). However, the existing members need the new members to see the established ways of working and the organisational world as they see it, or '*the way we do things around here*' (Vincent, 2010:272) The socialisation process in nursing begins at the start of training, whereby students are exposed to placements, and learn a cultural perspective that can be recreated in both the routine and unusual settings. This socialisation process was evident through a number of the texts, when participants described new roles or practice areas. It is particularly visible in Mel's text, when she describes becoming a manager and observing the established ways of working of her new, more junior staff, using positive role modelling techniques to influence their behaviour. Heidegger's (1927/2010) philosophy allows us to see how we learn to interact in new environments, in *zuhanden* and *unzuhanden* ways of coping, and how we conform to societal norms by adopting a *they-self* and relinquishing our own authenticity.

Participant's text articulated the notion of insider behaviour gained through friendships, understanding and humour. One participant, Caroline spoke of 'being in it together', where nursing friends could empathise and better comprehend issues in clinical practice. Martin (1992) observes the use of insider language, behaviour and humour as contributing to a sense of belonging within their own sub-culture. Indeed, insider behaviour is often borne through historical practice and rituals and unwritten rules, or listening to language, or humour, developing one's own shared knowledge (Alvesson, 2012). This idea is certainly reflected in Marie's text, as she describes her early nursing career, and the prevailing culture. Helman (2007) notes that culture is

made up of a set of unwritten rules, passed on through the use of ritualistic practice, symbols and language. Certainly, it must be acknowledged that the survival of any ongoing cultural behaviour is dependent upon the members of the culture sharing the same beliefs and perceptions (Helman, 2007).

The inability to promote change within the practice environment was highlighted by several participants in this study and was described at length by Marie, as she describes trying to remedy workload issues using official channels, without success. This was a central issue in the witness testimony from nurse, Helene Donnelly in the Mid Staffordshire investigation (Francis, 2013). In her statement, Ms Donnelly, (Donnelly, 2011) described raising concerns repeatedly through the reporting process, which never fulfilled any change in the environment. It seems fair to speculate, that the eventual situations which led to the Mid-Staffordshire inquiry would never have developed if the reporting process had been effective and invoked change. Paley (2013) criticises the Francis report (2013) citing that the occasions of poor care and staff indifference to requests for care were less of a result of a lack of compassion, and more an accumulation of inattentional blindness caused by unacceptable staffing levels and excessive workloads, causing nurses to fail to notice situations and events. Paley (2013) contests that the contextual pressures that staff were under is instrumental to the findings of the Francis report (2013) and that many of the recommendations made by the inquiry have been misconceived. Rolfe and Gardner (2014) argue strongly against Paley's (2013) reasoning, believing that the events documented at Mid Staffordshire were indefensible and that nurses should not attempt to excuse or rationalise any of the acts or omissions in care which occurred. Based on the findings from this study, nurses are often faced with challenging dilemmas, as they cannot exact change, yet continue to cope with workloads which can be unsafe.

The problems highlighted by the Francis report (2013) were also examined by Roberts and Ion (2015) who used the philosophical ideologies of Hannah Arendt (1971) to study and reinterpret the failings in a healthcare environment. Arendt (1971), herself a student of Heideggerian Phenomenology, asserts that in a society or organisation which encourages a high level of conformity, individuals often exhibit the '*authentic inability to think*' or '*thoughtlessness*'. Roberts and Ion (2015) apply this to the failings publicised in the UK healthcare system, proposing that staff become habituated to the

rule governing culture and conform to the social norms that have been established. This is reflective of Heidegger's theory of social conformity to *the-they*, in which individuals imitate and replicate behaviours and opinions, to adopt *they-self*, and an *inauthentic* mode of being. Certainly, this philosophical standpoint has been referenced throughout the study, and specifically in relation to raising concerns, when two of the participants demonstrated *inauthenticity*, that appeared to afford them a self-protective mechanism, as they made the decision not to raise concerns.

The findings of this study suggest that fear and blame were evident in the nursing culture in the individual's lifeworld. When Marie and Jean reminisce about their nurse training the historical legacy of a hierarchical profession bound in rules and regulations is evident. Vincent (2010) observes that nursing has attached penalties to mistakes or errors of judgement and discipline has tended to consist of public admonishment and the imposition of sanctions. The findings of this study suggest that this situation continues to present itself as evidenced in Caroline's text. Indeed, the Royal College of Nursing voiced their concerns about the "culture of fear and intimidation" in healthcare settings (Newcombe 2013:1; RCN, 2013). The Kirkup report (2015) also reported similar negative cultural behaviours of health care professionals that undermined healthcare and patient safety. Moreover, at the time of writing this, the UK Health secretary, Jeremy Hunt admitted the existence of a blame culture, and acknowledged the need for cultural changes to the NHS, making it a learning environment (Hunt, 2016). Plans by the CQC envisage the launch of staff surveys and inspections to gauge staff opinion on their feelings about safety concerns and support (Hunt, 2016). Hogan et al (2015) conducted a seminal retrospective case record review which investigated avoidable deaths in England, suggesting that 3.6% of hospital deaths have a 50% or more chance of being avoidable. This equates to there being potentially 150 avoidable deaths per week (Hogan et al, 2015). In monetary terms, it is estimated that unsafe care costs the NHS £2.5 billion, incorporating the costs of litigation, lengthier hospitalisation and repeat visits (Hunt, 2015).

In several of the participant's texts it was evident that their individual history, in terms of their background, training and experiences had influenced their current choices and behaviours. In Mel's text she reflected on role models and collegiality, and how this had shaped her career. Indeed, Gadamer (1975/1996) describes the effects of our

history and our historical awareness using the metaphor of standing in a stream of water, where it is impossible for the water not to touch us in every area of ourselves. The historical perspective of nursing is generally depicted as a very regimented and oppressed profession, which adopts rules, processes, and a code of conduct to ensure a uniform approach to both clinical tasks and professional behaviour. Indeed, Dubrosky (2013) asserts that cultural imperialism continues to influence oppressive group behaviours in nursing. Matheson and Bobay (2008) argue that oppression can lead to a loss of self-worth and can result in misplaced aggression and incivility towards colleagues. Demarco et al (2007) also note that nurses' abilities to self-advocate has been adversely affected by established systems and protocols. Moreover, Maben, et al (2007) posit that a task and efficiency focus by organisations can cause nurses to lose sight of their own ideals and values.

In summary, findings from this study, supported by evidence suggests that there exists a culture of blame in the NHS that is intrinsically linked to nurses' feeling undervalued and oppressed. This culminates in nurses' perceptions that they are helpless to bring about change. This perceived helplessness and acceptance of the negative environment appears to be rooted within the professional socialisation process and compounded by ineffective leadership and a flawed governance system. A key message that this study highlights is in the need to change the negative culture of nursing, by making nurses feel valued and their voices heard. Furthermore effective governance systems are essential in order to create a safe healthcare environment, which encourages openness and involvement from clinical staff. The work by Leonard and Frankel (2010) cited in Chapter Two of this thesis offers a sustainable solution for governance in the NHS that is both fair and transparent. The concept of governance is discussed later in this chapter, and also looks at the model of shared governance, which may have a synergy with Leonard and Frankel's (2010) work. Indeed, the vision conceptualised in both of the afore mentioned approaches focus on the pivotal positioning of effective leadership, which is accessible and engaged with staff. The issue of management and leadership in nursing is the next point of discussion.

Management and Leadership

The findings of this study indicate that participants experienced a remote and ineffective process of management. There was universal agreement from all participants that senior managers were rarely physically present in clinical practice, and therefore communication was made more difficult. Participants described communication with managers as being via email, as oppose to personal contact which seemed to add to their feelings of being less valued. This study also casts a light upon the influence which the management process has in relation to governance, collegiality, and the practice environment. The significance and importance of effective management and leadership in nursing has been the subject of literary debate for many years (Sutherland and Dodd, 2008). Earlier in this thesis, in chapter 6, I looked at two definitions of management and leadership, and made some brief comparisons. Whilst it could be argued that leadership is a function of a manager many scholars differentiate between what makes a leader and what makes a manager (Hughes et al, 2006). Armstrong (2016), asserts that management differs from leadership as it is concerned with attaining results and controlling resources, whereas leadership focuses on people and focusing on a vision for the future. Therefore, my assumptions in relating this information gained in this study are that participants are experiencing a management process as opposed to a leadership process. I am in no way using the terms manager and leader interchangeably, rather that I am being truthful to participants' terminology, and comparing this to literature and government policy that may use different terminology.

The data revealed multiple problems relating to management practices, emerging through participants' texts in a number of ways. Managers not being visible in clinical practice environments was articulated as a common concern, with communication frequently occurring through email, rather than face to face. This remote style of management led participants to feel less valued and isolated from any decision making. One participant, Gemma, went so far as to say that she was only given information to protect managers if things were to go wrong, so that the managers could testify to having told staff. Several participants offered thoughts on the fact that managers lacked empathy and understanding for nurses' everyday pressures, leading to the perception of division between front line staff and the management team. It

would seem that participants had expectations that their managers should possess leadership qualities, as well as managerial skills, a point that is reflected in the World Health Organisation's (2014) descriptions of a manager and a leader quoted in the chapter 6.

Data from this study found that effective management and good leadership are intrinsic factors in healthcare delivery. Participants describe feelings of being unvalued and disconnected from service development and experiencing an ineffective management process. Indeed, a study by Hahtela et al (2014) found that a negative style of management and a poor organisational commitment to its staff related directly to nurses' absentee rate, overtime, occupational injuries and staff retention. This was concurred by Schreuder et al. (2011) which also observed that nurse managers' leadership style was associated with nurses' sickness rates. Furthermore, negative organisational outcomes were found to be associated with avoidance style leadership in a UK study undertaken by Jackson et al (2013). Effective leadership was also directly linked to healthcare reform, system performance and integrity, staff morale and retention as well as underpinning the existence of the safety culture of the organisation (MacPhee et al, 2013; Siriwardena, 2006). Indeed, evidence by Anderson et al (2010) highlighted the importance of nursing leaders being visible and accessible. This was concurred by Boomer and McCormack (2010) who assert that it is essential that managers are actively involved in creating a positive practice environment, where nurses can flourish. The importance of authentic leaders to newly qualified nurses in Canada was investigated by Spence-Laschinger et al (2015) using a cross sectional survey approach. The study found that positive leadership skills benefited individuals in a variety of ways including increased self-efficacy, wellbeing, and resilience, whilst affording them protection from burn-out and poor mental health. However, it must also be acknowledged that a positive style of leadership can only be effective if supported by organisational change to structure and policy (Martin et al, 2011).

This study also found the existence of bullying in nursing, manifesting itself in both overt and covert ways. It appeared that this negative aspect of nursing culture is directly linked to the idea of poor management, a situation witnessed in Mel and Dawn's text. Moreover, Incivility in nursing culture was expressed from the perspective of bullying by peers, and of managerial bullying. In both situations' participants felt

intimidated and expressed feelings of fear and anxiety. Workplace bullying is defined by Einarsen et al (2009) as sustained and recurring exposure to negative and unreasonable behaviour from other staff. Most participants employed self-protective modes of coping, choosing either to tolerate it or else leave the environment. One participant Mel confronted the perpetrators, but initially received no assistance from senior managers. Indeed, it appeared that the main source of support in each of the participants' experience of bullying, came from other colleagues, which intersects with the idea of management being ineffectual. Certainly, the issue of incivility in nursing has been the subject of literary debate for many years (Carter et al, 2013). For those individuals who directly or indirectly experience bullying, the effects can influence their physical and psychological health and can adversely impact patient safety as nurses' potential to make medical errors increase (Farrell et al, 2006). An NHS survey in 2015 involving 300,000 healthcare professionals across England reported that a quarter of staff had experienced some form of bullying or abuse in the previous 12-month period (NHS Staff survey, 2015).

The literature on the subject of bullying further reflects that negative practice environments are also linked to higher incidents of nurse burnout (Laschinger et al 2009; Stone et al, 2007) job dissatisfaction (Laschinger et al., 2013) and higher mortality rates (Aiken et al, 2008). Furthermore, the outcomes of such experiences on organisations are decreased productivity, an increase in staff sickness, poor staff retention and recruitment as well as decreased communication ((Hutton & Gates, 2008; Rowe and Sherlock, 2005). Workplace bullying is a concept that is complex and sometimes problematic to define (Branch et al, 2013). The term workplace incivility is also used in the literature to relate to bullying, abuse, conflict, incivility, and lateral violence, in the workplace (McNamara, 2012; Khadjehturian, 2012). Bullying behaviours can be overt or covert, and include threats that undermine individuals' professional position, such as criticism, intimidation, and humiliation (Moayed et al. 2006). Bullying can take the form of socially isolating victims, by denying them information and ignoring their communication processes (Moayed et al, 2006) or even ostracising them from the group (Caza and Cortina, 2007) . A Turkish study by Yildirim and Yildirim (2007) found that covert bullying can be manifested through excessive workload and deadlines being set, resulting in performance monitoring when individuals fail to cope with the demands that are put upon them.

This study offers some insight into why bullying in nursing remains an unresolved problem, in respect of how ineffective management allows it to continue. Indeed, the literature fails to give definitive reasoning as to why bullying occurs in nursing. Hutchinson et al (2006) argues that it may be due to the organisational structure of healthcare and reflects upon Foucault's (1977) *conceptions of power theory*. In contrast Curtis et al (2007) utilises the theory that nursing is part of an oppressed group, which have been suppressed by the medical establishment (Simons, 2006). Randle (2003) offers a socio-cultural perspective on bullying, observing that student nurses are exposed to bullying early in their training, and experience pressure to conform to the cultural norms that are apparent, a viewpoint reflected in Marie's text. A study by Randle (2003) also warns of the adverse consequences of negative role models that survive through a professional socialisation process. Becher and Visovsky (2012) observe that nursing managers have a duty to hold themselves and their staff accountable for their actions in relation to workplace incivility having the capacity to ensure support and education. Khadjehturian (2012) concurs with these findings, adding that effective leadership should develop supportive and trusting relationships amongst staff, building positive cultures. Indeed, leadership is considered the most significant aspect in influencing organisational culture, and positively affecting staff behaviours according to a report by the Kingsfund (West et al, 2015). At many junctures, participants in this study, have depicted a hierarchical structure in their experience of working in the NHS. This is particularly vivid in Marie's text, as she describes the changing landscape of the health service. It would therefore seem pertinent to explore the issue of management and leadership in the NHS and how it has developed in recent years.

The NHS, by its own admission has operated a 'command and control culture' over the past few decades (NHS Leadership Academy, 2013:5). The ethos had been one of shared, collaborative leadership which as an organisational approach produced a weak and often blurred understanding of roles and a lack of clarity in thinking amongst management. The programme which extolled these shared leadership theories were the Leadership Qualities Framework that was introduced in 2011 (NHS leadership academy, 2011). However, this framework witnessed challenges for managers who found conflict between the taught values, protocols and routine practice. The

leadership model was consequently changed towards autonomy, responsibility and accountability, whilst recognising that quality care, delivered with compassion in a timely and effective way was paramount. The NHS academy (2013), when referring to the leadership of staff said that managers should be mindful of 'meeting the need to mobilise human motivation, whilst also regulating it and making it dependable and predictable' (NHS academy, 2013:5). Following the Francis report (2013) The Leadership Framework was superseded by the Healthcare Leadership Model in 2014 (NHS leadership academy, 2014). This was followed by the 'professionalisation' of leadership program, '*Developing better leaders, and delivering better care*' was launched, which embraced the importance of effective leadership in all levels of the NHS. (NHS leadership academy, 2015). The five-year plan saw the inception of several new programs, designed for new manager's right through to chief executives. The point of these separate modules was to target individual needs to prepare leaders with the necessary skills, knowledge and behaviours required at their particular level. The Kings fund (West et al, 2015) identified effective leadership as the key most influential factor in changing the organisational culture of the NHS, to be able to provide high quality, safe and compassionate patient care. It conceded that it was imperative that new initiatives were undertaken to ensure that the correct leadership strategies, and behaviours were created in NHS managers.

Participants in this study clearly vocalised their need for supportive management and leadership and acknowledged the potential benefits it could deliver. In Dawn's text she speaks of her frustration at managers not tackling known 'bad wards'. Indeed, poor organisational management and lack of leadership has been a central focus of the majority of government investigations into healthcare failings (See Chapter 2 table 2). The senior management at many of the hospital trusts investigated, focussed upon their corporate goals and paid little regard to patient centred care. The recommendations from the Francis report (2013) and Berwick review (2013) were to create patient-centred healthcare leadership, which would redevelop professional training and management and create a new culture based on honesty, openness and integrity. The new leadership framework aimed to highlight patient safety, and afford an accreditation to NHS leaders, specifically nurse leaders. Berwick (2013) called for a new framework of safety leadership behaviours, which would permeate through organisations via a new appraisal system. A new leadership academy was created as

a result of these two high profile reports (Francis, 2013; Berwick, 2013) acting as a vessel to encourage innovative and aspirational leadership throughout the NHS. The new visions for leadership with a forward thinking and motivational framework were introduced three years prior to this study, and yet it has been difficult to find evidence to suggest that participants have experienced any of its effects.

Findings from this study observe that participant's found management to be remote, ineffective and disconnected from staff. Heidegger's (1927/2010) philosophy could therefore offer useful solutions to this issue, addressing the need for effective leadership, by using the concept of *care* (*Sorge*), *concern* (*Besorgen*) and *solicitude* (*Fursorge*). Heidegger (1927/2010) theorises that *solicitude* can take the forms of *leaping-in* and *leaping-ahead*. The following quotation captures the dichotomy between the two differing methods of concern:

“With regard to its possibility modes, concern has two extreme possibilities. It can, so to speak, take the other's “care” away from him and put itself in his place in taking care, it can leap in for him. Concern takes over what is to be taken care of for the other. The other is thus displaced, he steps back so that afterwards, when the matter has been attended to, he can take it over as something finished and available or disburden himself of it completely. In this concern, the other can become someone who is dependent and dominated even if this domination is a tacit one and remains hidden from him. This kind of concern which does the job and takes away “care” is, to a large extent, determinative for being-with-one another and pertains, for the most part, to our taking care of things at hand. In contrast to this, there is the possibility of a concern which does not so much leap in for the other as leap ahead of him in his existentiell potentiality-of-being, not in order to take “care” away from him, but rather to authentically give it back as such. This concern which essentially pertains to authentic care — that is, it pertains to the existence of the other, and not to a what which it takes care of - helps the other to become transparent to himself in his care and free for it. (Heidegger 1927/2010:122)

Heidegger (1927/2010) observes the nature of concern using the concept of *temporality* and *authenticity*. *Leaping-in* occurs within the boundaries of the past and

present, whereas *leaping-ahead* involves the future, and our *potentiality* (Heidegger, 1927/2010). It is clear that a combination of the two could be a useful analogy, to apply to the issue of leadership. The balance to be had here lies in the individual, who is engaged in-the-world with care, and concern for others. It relies on being able to know when to *leap-in*, and when to *leap-ahead*, along with an understanding of the consequences for both interactions and grounded in a *solicitudes* mode of consideration and tolerance of others. Heidegger (1927/2010) reiterates the need to understand ourselves, our lives and our relationships with others.

The concept of a Heideggerian model of leadership adds to the debate on leadership theory, demonstrating clear comparisons with *transformational leadership* and *authentic leadership*. 'Transformational leadership' was a concept developed by Bass and Avolio (1994) and described the features and characteristics of effective leaders. The original '*full range leadership theory*' conceptualises a continuum ranging from 'highly transformational' to 'transactional', to 'laissez-faire' (Bass and Avolio, 1994). Positive effects of transformational leadership have been found in relation to work-life balance, staff well-being, positive nursing outcomes, and patient safety (Wong et al, 2013). Authentic leadership emphasises the importance of building trust by valuing the contributions of staff and role modelling (Wong and Cummings, 2009). Moreover, authentic leadership supports and empowers staff through integrity and transparency leading to improvements in job satisfaction and increased standards of care (Peterson et al, 2012). Indeed, the attributes characterised in transformational and authentic leadership styles would have natural synergy with a Heideggerian approach of *leaping-in* and *leaping-ahead*.

This study adds new insights to the existing body of knowledge, in relation to how management processes are perceived in the practice environment. It was found that supportive management had positive effects upon staff performance, retention and individual wellbeing. Moreover, effective management would have a positive impact upon culture and has the potential to eradicate much of the incivility that exists in nursing. The participants in this study could clearly articulate their need for supportive managers, and Heidegger's philosophy offers some important insights which could inform thinking in this aspect of practice. At times, when participant's experienced excessive workload demands, and requested physical help with nursing duties, a

leaping-in approach may have been beneficial, if this were performed with care, tolerance and consideration. At other times *leaping-ahead*, facilitating a sense of empowerment, could help them to feel valued and assist them to realise their own possibilities. If a Heideggerian model of management was combined with a transformational or authentic style of leadership, then this could offer beneficial outcomes, in terms of practical support for nurses. Effective management and leadership are pivotal concepts that could help to create a positive environment and increase staff motivation and resilience in nursing. A supportive system of management that actively listens and engages with staff could facilitate staff collegiality and combat incivility, ensuring a safe *dwelling* place for practice and development.

Professional accountability

This study has sought to explore how nurses perceive and experience professional accountability in their everyday lives, and as such adds unique understanding to the existing literature, since this phenomenon has not been well researched previously. Participants spoke about their perception of professional accountability, defining where their accountability and responsibility lay. Since this concept presents itself as the foundation to this study, and indeed to nursing practice it is an important phenomenon to explore. All the participants could explain the concept of professional accountability in terms of definition, but also articulated what it meant *to be* a registered nurse. Participants noted their professional accountabilities to their patients, organisation and regulatory body, whilst also observing their personal accountability. There was evidence in this study of the emotional effects of being a nurse, and this concept is explored in the next section but remains very much linked to the way nurses' experience professional accountability. Moreover, participants described their own perceptions of their practice environments and its effects upon their ability to provide care in line with their own professional ideals.

Findings from this study observed that ineffective reporting systems meant that participants were unable to change their practice environment despite raising concerns. In the UK, information relating to patient safety has been obtained using incident reporting systems, with the intention of allowing individual and organisational learning (Currie et al, 2008). Critics have argued that this method of reporting adverse events and incidents is bureaucratic, time consuming, inaccurate (Wachter, 2009) and holds fear of recriminations for staff (Vincent et al, 2014). Furthermore, Spurgeon et al (2017) note that the incident reporting system in health is not proving effective in reducing the adverse events connected to patient harm. The most recent development in incident reporting was launched in March 2017 and will introduce 'the Patient Safety Incident Management System' NHS improvement (2017) over the next three years. The new system of reporting will integrate with existing systems, whilst promoting confidentiality and transparency.

This study also found that reporting incidents could be problematic and anxiety provoking. Gemma and Dawn recalled their experience of reporting concerns relating to the practice environment being met by hostility from managers. The literature supports these findings and are reflected in a study by Blenkinsopp and Snowden (2016) who report that a culture of silence develops when senior managers respond to concerns with hostility or fail to act at all. Furthermore, Jones (2016) asserts that staff concerns are often ignored by senior staff with a responsibility to taken action. In a study by Jackson et al (2013) investigating the issues surrounding whistleblowing it suggests that managers may practice avoidance style leadership when confronted with staff raising concerns. Attree (2007) concurs with this, noting avoidance strategies by managers as being a common feature that acts as a barrier to raising concerns in the healthcare environment. Indeed, the Francis report (2013) documented that 940 complaints of dangerously low staffing had been made to the National Patient Safety Agency between 2005 and 2010, and that action had failed to be taken. A seminal work by Weinstein (1979) proposed that managers often responded unfavourably to whistleblowing because of the inference of organisational failure that they saw as a reflection of their own identity as a leader. In contrast, Blenkinsopp and Snowden, (2016) suggest that leaders who are seen as role models, who are accessible, approachable and visible would promote confidence in nurses to raise concerns.

However, the willingness of staff to be open and honest also relies on the effectiveness of governance systems; this is the next issue for discussion.

Key findings from this study have highlighted the fundamental need for strong governance in healthcare. Participants discussed the risk management system in relation to raising concerns, and its impact upon their individual accountability. Gemma describes the increasing bureaucracy, audits and targets which are adhered to at the expense of the patient's wellbeing. In Caroline's text she observes a flawed process of accountability, as staff are blamed for errors despite system failures. In chapter One, I looked at Leonard and Frankel's (2010) framework for the creation of a positive culture, which emphasises the need for effective leadership, which is visible, and engaged with healthcare staff. Kutney-Lee et al (2016) suggests that shared governance may be a positive step towards nurse engagement, retention and increased patient safety. Indeed, Hess and Swihart (2013) defines the principles of shared governance to be in creating partnerships based on equality, accountability and ownership in care provision, thus empowering all members of the healthcare team to be involved in decision making. Taylor (2016: 20) describes shared governance as staff having 'collective ownership to develop and improve practice, to ensure patients receive caring, safe and confident care'. The concept of valuing nurses' contributions has also been linked to job satisfaction (Tourangeau et al, 2010) Participants in this study described the need to feel valued and involved in decision making, as oppose to feeling disconnected and unappreciated, as was evident in Adam's text. Moreover, Hess and Swihart (2013) asserts that shared governance has the potential to facilitate the shared vision of the organisation to increase standards of healthcare provision. George (2014) emphasises that a system of shared governance would transform the culture of organisations by involving staff in decision making and thus empowering the workforce, but requires transformational leaders to implement such changes in practice.

It is clear that changes to the NHS governance systems are required to fulfil the original mandate of establishing an environment that ensures high standards of care (DH, 1997). Clinical governance was introduced to standardise policy and approaches in clinical healthcare, and emphasised accountability and responsibility within the NHS (Scully and Donaldson, 1998). Whilst the relationship between governance and

accountability is clear, the goal of learning through mistakes in order to improve, is being damaged by the threat of control and sanctions (Denis, 2014). Indeed, sanction-based accountability could be replaced with accountability that is rooted in trust and underpinned by effective governance (Mansbridge, 2014). Certainly, an imbalance in accountability exists whereby nurses are expected to be 'called to account', and accept sanctions without question (Mulgan, 2000:1), whilst organisations are not required to 'give account' (Pollitt, 1990:151) and provide adequate means for care provision. Indeed, organisations have historically often failed to provide effective staffing and adequate resources needed to provide safe care (see Table 2). Failures in healthcare discussed in Chapter Two, demonstrated the failure of executive boards to prioritise standards of care. Instead focus has been on finance, status and external performance standards (See Table 2). Attention on the role, experience and expertise of board members is now increasing, both in the UK, and globally (Mannion et al, 2016). Board-level governance of quality of care is to be strengthened by new leadership programs, designed to increase accountability (NHS Leadership Academy, 2013a) The *single oversight framework* proposed by NHS improvement will work jointly with the CQC to hold provider organisations to account for governance, operational performance, financial efficiency and strategic change (NHS Improvement, 2017).

Participants all shared a negative view of the NMC, and the lack of support which the regulator appeared to show its members. All of the participants appear to resent the increasing registration fees, and the poor public image which the NMC generates, Marie's text perhaps sums this up as she described her registration payment as 'money for old rope' meaning she got nothing out of it. Whilst nurses are accountable to the NMC, equally the NMC is accountable to the UK Government, the public and its registrant body. The NMC is regulated by the Professional Standards Authority for Health and Social Care. Since 2011, the Commons Select Committee has held annual accountability hearing with the NMC to scrutinise its work and make recommendations regarding its development (NMC, 2017b). The PSA (2017) are currently investigating the NMC in relation to its handling of the Morecambe Bay investigation (Kirkup, 2015) at the request of the Secretary of State for Health. The NMC code (2015a) sets out the *Professional standards of practice and behaviour for nurses and midwives*. The NMC (2015a:2) state that

‘While you can interpret the values and principles set out in the Code in a range of different practice settings, they are not negotiable or discretionary’.

The notion that the values and ideals of holistic nursing care was a non-negotiable part of nursing was also articulated by the participants in this study. However, participant’s felt compromised by insufficient resources necessary to fulfil their practice ideals, which resulted in moral distress. In light of strong evidence relating to nurses’ inability to properly uphold the NMC code (2015a) due to organisational limitations, there appears no audible support from the NMC. Indeed, the NMC fails to hold employers responsible for resource availability, choosing to place accountability for patient safety solely with nurses (NMC, 2015b). Peter Carter, former RCN chief executive asserted that the NMC lacked authority in setting standards for organisations and should protect nurses by having power to legislate on working hours, staffing ratios and clinical standards (Merrifield, 2016). In contrast the General Medical Council (GMC, 2015) demonstrate concern for their registrants by calling upon the NHS to support junior doctors in exception reporting to highlight poor staffing and protect training needs. The NMC state categorically that they have no role in lobbying Parliament (NMC, 2013) However, the NMC Strategy 2015–2020 (NMC, 2015) does pledge to work more closely with other regulators, such as the CQC in order to achieve a more proactive approach.

From a Heideggerian perspective this study draws reference to Heidegger’s (1927/2010) care structure in relation to professional accountability, as we are *always in-the-world* with care, and it is with *care* and *solicitude* that we interact with our environment, objects and others. This study has shown how participants adopted both *authentic* and inauthentic modes of being, often taking on a *they-self*, and conforming to *the-they*, a situation which is observed in Gemma’s text as she discusses raising concerns. Heidegger (1927/2010) theorises that in our *belonging-to-others* and adopting a *they-self* then we deny *Dasein* its own accountability, allowing *the-they* to make decisions. In this way *the-they* can be viewed as being responsible for consequences which occur. Heidegger (1927/2010) calls this *the self of everyday Dasein* and is the opposite of *authenticity*. This was particularly visible when participants spoke about raising concerns, when two of the participants chose a self-

protective approach of *inauthenticity* to avoid the possible *angst* which may come from confronting *the-they*. It is the *angst* that brings *Dasein* back to face the moment of deciding whether to remain in *inauthenticity* or else adopt an *authentic* mode of *being*. Heidegger's (1927/2010) thoughts on *conscience* are also of relevance here, depicted as a *silent call*, that pulls us back from the busy hubbub of everyday life to *our-self*. In order to become *authentic* we need to understand the *call of conscience*, and take it into our self.

Professional accountability in nursing is fundamentally linked to professional ideals, and the provision of high standards of patient care. Employing organisations, and the NMC (2015a) charge nurses with professional accountability for their actions in relation to providing safe effective care. However, the NMC does not call health provider organisations to account for deficiencies in resources needed to carry out such standards. Evidence from this study, which is supported by the available literature, suggest that concerns raised regarding the practice environment are frequently ignored, and change does not occur. Whilst sanction based accountability is in operation, there is a deficiency in trust and honesty, exacerbating a blame culture. It is acknowledged that recent proposals by NHS improvement (2016) seek to address the historical lack of accountability in board governing bodies, although this should arguably have been addressed decades earlier in light of failures in healthcare provision (See Table 2). This study centres on nurses' professional accountability, and the need for changes in culture, management and governance, that would create a more positive practice environment to nurture and support nurses. Evidence suggests that shared governance models, when supported by transformational leadership may offer some solutions in creating an engaged and motivated workforce. At the beginning of this chapter, I acknowledged that there was an emotional element with regard to nurses' professional accountability, and I would like to consider this aspect in the next section.

The emotional costs of nursing

This study adds to the existing body of knowledge, relating to the understanding of the emotional costs of nursing. Findings reveal the dilemmas and complex challenges that nurse's face in their everyday working lives. Importantly this study also uncovers the

existence of fear in the nurse's lifeworld, and describes how nurses cope in difficult situations, when their professional accountability is compromised. Emotion was evident throughout participants' texts as they described their everyday experience of *being* a nurse. Moreover, participants related their conflicting feelings between how it felt to be a 'good' nurse, and the frustration of not having enough time to fulfil their ideals in practice. This is particularly visible in Marie, Caroline and Mel's text as they discussed not having enough time to nurse holistically. This dichotomy in workplace ethics was presented as '*moral distress*' in the literature. Moral distress is defined in seminal work by Jameton (1993) as occurring when nurses are faced with situations whereby organisational constraints prevent them from taking ethically appropriate actions, or in other words knowing what to do but not being able to do it. An American study by Whitehead et al (2015) suggests that moral distress is a common experience for nurses and is associated with intention to leave the profession and burn-out. Sources of moral distress highlighted in the study by Whitehead et al (2015) came from nurses witnessing a decrease in the quality of patient care due to reduced continuity and poor communication. Bandura (2006) suggests that the potential effects of the phenomenon of moral distress includes moral disengagement and negative influences upon multi-disciplinary relationships, patient safety and family care. Indeed, research shows that moral distress is not exclusive to nursing, and effects all healthcare professionals (Gaudine et al, 2011). Furthermore, Gaudine et al (2011) reports that moral distress is also experienced by healthcare leaders, who feel trapped between the demands of administration and the concerns of clinical care practitioners, a point referred to in this study.

Another issue explored in this study, within the context of professional accountability was the issue of emotional labour and was conceptualised by Gemma as the '*person behind the nurse*'. The emotional nature of nursing receives attention in the literature in a number of guises, as emotional labour, emotional intelligence and emotion work. Emotional labour, is defined by Brotheridge and Lee (2003:365) as occurring when "*employees regulate their emotional display in an attempt to meet organisationally-based expectations specific to their roles*". In nursing the majority of patient care will involve a degree of emotional management in one way or another. Indeed, Goffman (1959) reports that our behaviours and actions are modulated to fit in with societal norms and organisational expectations, guided by '*the invisible hand*'. Emotional

labour is often seen as being synonymous with empathy but has also been linked to emotional dissonance or discord when nurses' emotions are not compatible with societal or organisational norms (Traynor, 2017). Emotional labour has close associations to stress and anxiety and was widely cited in the literature. Smith (1992) carried out a seminal piece of work in this area, looking at the emotional labour of student nurses. Smith (1992:7) asserts that emotional labour can be viewed through the interpersonal exchanges of staff, allowing employers to influence *through training and supervision to regulate a degree of control over the emotional activities of workers*. Hochschild (1983) adds to this by proposing that emotional labour encompasses the suppression of emotion so that patients have a sense of security and trust in staff. Grey and Smith (2009) examined the role of emotional labour in relation to different clinical settings, concluding that emotional labour was an essential part of nursing, but also that there was further research required looking at patients' perceptions of emotional labour. Furthermore, Hochschild (1983) asserts that individuals manifest their display of feelings using either surface acting, or deep acting. Humphrey et al (2015:749) describes surface acting to mean 'faking emotion', and deep acting to mean trying to feel the appropriate emotion which is to be conveyed. The relationship between emotional labour and emotional intelligence has been the subject of much research (Austin et al, 2008). Emotional intelligence is described by Goleman (1998), as the combination of self-awareness, self-regulation, motivation, empathy, and social skills, whereas Mayer and Salovey (1993), saw emotional intelligence as the capacity to perceive, integrate, understand and manage emotions, in order to aid personal and professional development. Mayer et al (2008:507) later developed this theory to conceive that emotion could be reasoned, and as such 'emotions and emotional knowledge could be used to enhance thinking'. McQueen (2004) comments that if the importance of emotional intelligence is realised, then the value of emotion can be appreciated instead of suppressed. Indeed, Karimi et al (2013) found that emotional labour can be moderated by emotional intelligence to reduce stress and improve well-being in nursing. Furthermore, Sadri (2012) notes that effective leadership can be enhanced by a greater understanding of emotional intelligence, a point echoed by Akerjordet and Severinsson (2008).

The media portrayal of nursing as a 'troubled profession' (Girvin et al, 2016) had also influenced the way that the participants felt about the public's perception of them, and

how it felt to *be a nurse*. Indeed, participants in this study spoke of the public's changing perceptions and expectations of nurses in light of public inquiries, which have arguably levied criticism on the entire nursing profession. The notion of professional identity is defined by Fagermoen (1997) as 'the values and beliefs held by nurses that guide her/his thinking, actions and interactions with the patient'. Studies show that there exists a congruence between the public persona of nurses and nurses' own self-concept with nurses who feel a negative public image being more likely to feel low self-concept (Ten-Hoeve et al, 2013) These findings were concurred by Tzeng (2006) who went onto to conclude that nurses who exhibited negative self-concept in turn influenced the public opinion of nurses in a negative light. Self-concept is defined by Tajfel and Turner (1986) as 'the way we think about ourselves'. Takase et al (2002:197) offers the definition of nurses' self-concept as; 'the information and beliefs that nurses have about their roles, values and behaviours'. The terminology used here in self-concept is applicable to the professional *self* rather than using the term self-image or self-esteem, which would convey a link to the individual or psychological self and how they see themselves as people as opposed to nurses.

A systematic review by Ten-Hoeve et al (2013) concludes that the inconsistent and sometimes damaging media portrayal of nurses is perpetuated by nurses' own 'invisibility and lack of public discourse'. For decades there has been a persistence in the media for the use of nurse stereotypes (Gross, 2017). Work by Kalisch and Kalisch (1983) revealed the historicity of the image of nursing corresponding to the cultural context of the day: Angel of Mercy (1854–1919); (2) Girl Friday (1920– 1929); (3) Heroine (1930–1945); (4) Mother (1946– 1965); (5) Sex Object (1960–1982); and (6) Careerist (1983–Present). Indeed, a more contemporary study by Kelly et al (2012:1807) found that nursing continues to be depicted in stereotypical images, with three identity types; as 'a skilled knower and doer', the nurse as 'a sexual plaything' and the nurse as 'a witless incompetent individual'. The use of such stereotypical imagery does not encourage a positive public perception of a competent and autonomous practitioner (Gross, 2017; Neilson and Lauder, 2008). Furthermore the negative portrayal of nurses by the media may adversely affect recruitment (Morris-Thompson et al, 2011). Indeed, undervaluation by stereotypical depiction in the media could lead to a profession that lacks both public respect and organisational power. Summers and Summers (2009) warn that the negative media portrayal of nurses can

have a detrimental impact upon recruitment, and in turn, future health provision. A systematic review and narrative synthesis by Girvin et al (2016) carried out from 2010 to 2015 found that nursing is often depicted as a 'troubled profession' with investigations often documenting failures in care provision and nursing shortages. This negative portrayal of nursing undoubtedly effects the morale and self-image of individual nurses, a finding which is supported by the data from this study.

A common concern, raised by participants, was their reduced ability to provide person centred care, which was perceived as a non-negotiable part of nursing. The participants expressed their sadness, anger and frustration at not being able to nurse in a manner they felt they should be able to. Similar findings are echoed in the literature finding that nurses' beliefs in holistic care and clinical experience contribute to their resilience (Cameron and Brownie, 2010). Indeed, an interpretive phenomenological study by Ablett (2007) exploring the experiences of Hospice nurses found that resilience and well-being was positively impacted by nurses' sense of ideals and a desire to provide holistic care, which would enhance quality of life.

This study adds new evidence to the body of literature, as it discussed the concept of fear which was experienced by individuals in a variety of settings. For Marie, she spoke of fear in new environments, and Mel, as she faced new roles. Fear is not a subject which seems to have been well researched in respect of the nurse's lifeworld yet presents itself as an interesting and complex phenomenon. Heidegger's (1927/2010) work has much to add to this discussion when looking at the self, and our perceptions of emotion. Heidegger (1927/2010) explains that *Dasein* is always personal and denotes the interconnectivity of the influential contexts that shape and afford meanings to our lives. *Dasein* is encompassed by tradition, historicity, and culture that become contextual layers of our makeup, undisclosed and non-apparent because they have become part of our taken-for granted identity. When referring to emotion, Heidegger (1927/2010) conceives emotion and mood as modes of attunement. Moods or emotions are seen by Heidegger (1927/2010) as the emotional effects of being-in-the-world. He posits that moods are not only evident within our minds, as a mental state which changes, but also in-the-world. He describes these moods of attunement as coming from our *being-in-the-world*, not coming from within ourselves. In fact in conversation, we can describe ourselves as *in a mood*, as opposed to the mood in us.

Therefore, our mood comes from our *being-in-the-world* (Heidegger (1927/2010) Anxiety is described as a basic mood when the self can become self-aware, and able to adopt freedom and therefore authenticity. In Heidegger's (1927/2010) thoughts on *discourse*, he reminds us of the benefits which are derived from listening to others and from sharing our own thoughts, allowing us to better comprehend ourselves, and our world. In this way, anxiety can be lessened as problems are discussed and rationalised.

It is clear that nursing involves a great deal of emotional investment of the self. The participants displayed and articulated the emotions of fear, hope, anger, joy, frustration and satisfaction. There was evidence of compassion and of sadness, as they spoke about their experiences of *being* a nurse. All participants spoke of the historical, political and social contexts that impacted upon their ability to nurse. There was emotional distress as they observed the dichotomy between how they wanted to nurse, and the reality of nursing. From the experiences of a newly qualified nurse, to the mature nurse, who prepared for retirement, there were commonalities in their discourse. Being a nurse is clearly a complex role that involves challenges and emotional hurdles to overcome. As a nurse myself, I could relate to all their experiences, often finding it emotionally draining, as I remembered past events and incidents, which I had not thought about for many years. Being a nurse is at times extremely difficult, and stressful, yet extremely rewarding and satisfying. When these difficulties are related to patients' health needs such as symptom control, it draws on experience, and multidisciplinary working, which is navigable. When difficulties prevail which are political and financial, these seem more difficult to traverse, and become frustrating and anger provoking. The negative portrayal of nursing by the media also appears to have detrimental effects on both individual nurses, and the profession of nursing as a whole. Findings demonstrate that nursing needs positive role models and effective leadership if this situation is to change. This study also presents resounding testament, to demonstrate that whatever the situations that participants found themselves in, they strived to give their best. Participants clearly articulated the positive qualities which they observed in themselves and their peers. Finding coping mechanisms to deal with the emotional challenges in nursing, will therefore be presented in the next section, pertaining to resilience in nursing.

Resilience in nursing

Resilience in nursing presents itself as an overarching issue in many of the participant's texts, as they describe how they have experienced adversity in their working lives, and careers. This study therefore adds to the existing understanding of resilience, revealing not only how nurses cope with the daily stresses of nursing, but also how they can be better supported in practice. The presented texts observed the reality of the excessive workloads and inadequate staffing that had emotional, physical and psychological effects upon them. Adversity also presented itself through bullying and stressful clinical situations. Mel describes all of these events in narrating her experiences of her career. However, despite these complex challenges that were encountered by the participants, the nurses were able to demonstrate resilience and remain caring and compassionate professionals. Resilience is often a concept aligned to nursing to describe the ways in which individuals cope and adapt to the stressful environment of care provision. Gillespie et al (2007:133) describe resilience as "*an ongoing process of struggling with hardship and not giving up*". Certainly, this ethos is present in many of the participant's texts, not least in Dawn's text as she describes several stressful situations. The challenges and unpredictability of the healthcare setting mean that nurses are constantly modifying and changing their behaviours to deal with the stresses that are apparent in their daily working lives (McAllister and McKinnon, 2009). Moreover, Pines et al (2014:86) offer a definition of resilience as 'the ability of an individual to adjust to adversity, maintain equilibrium, retain some control over the environment and move in a positive direction.' There is also a positive relationship between resilience and empowerment in student nurses (Pines et al, 2012). Hodges et al (2010) found that stress resiliency positively influences nurse retention. Furthermore resilience is shown to increase job satisfaction and retention in nurse leaders (McDonald et al, 2013; Hudgins, 2016). McAllister and Lowe (2011) assert that resilience in nursing derives from not only surviving adversity, but from personal growth resulting from learning from the adverse experience. Overall, this study supports the literature suggesting that resilience is a protective mechanism to our wellbeing in times of stress (Hudgins, 2015). However, it is important to note that resilience should not be seen as being synonymous with strength, as the inference is often implied. Hudgins (2015) makes this point well, describing strength as being able to withstand adversity, whereas

resilience is learning through adversity. Certainly, there seems to be a positive relationship between developing emotional intelligence and resilience on the ability to cope with work related stress (li et al, 2015).

Resilience theorist, Ungar (2008) asserts that the quality of the environment or how successfully individuals adapt to their environment is a predictor of resilience, in spite of the number and scale of adversities they face. Indeed, Neenan (2018) posits that resilience is about managing emotion, not in social isolation, but through discourse and support, a point made by Jean, as she views the practice environment. However, there is a danger that vulnerability can be viewed as a sign of weakness, and resilience as a measure of proficiency (Taylor, 2016). Neenan (2018:6) concurs with this view, asserting that 'absolute resilience' is not a possibility since adversity is a subjective phenomenon, and therefore vulnerability exists in all individuals. Findings from this study support the literature in advocating the importance of colleague support which appears to positively influence nurses' ability to thrive and therefore increase personal resilience, a point which is also concurred by McDonald et al (2015). I will therefore explore the nature of collegiality in the next section.

Collegiality was witnessed by the participants in this study to be an important motivator, and provided a pivotal coping mechanism with which to deal with stress, therefore adding to the concept of resilience. The participants' conceptualised collegiality as affording them job satisfaction, and support, allowing them to cope better under elevated work pressures. An example of this would be in Mel observations as she talked of the importance of colleagues. Collegiality epitomised team working, and the security and sense of belonging which that invoked. The support from colleagues also allowed a sense of safety and *dwelling*, where individuals could develop and be nurtured. For academic advancement, peer support was extolled as a prerequisite for a productive learning environment in Dawn's text. Marie also gives testament to collegiality being paramount to resilience and retention, especially if there was a lack of leadership, to motivate and care for staff.

The literature supports the findings of this study, describing collegiality as relationships that are built on respect, trust and support (Mathes, 2011). Collegiality is often described as the first line of self-regulation in nursing (Padgett, 2013). Moreover, a

study by Kalisch et al (2007) asserts that collegiality is commonly associated with teamwork, communication, and collaboration, finding that greater teamwork and engagement is beneficial to both staff and patients. It is also noted that a positive practice environment, involving collegiality is instrumental in increasing nurse retention as well as improving the quality of patient care (Twigg and McCullough, 2014). The literature also reveals that colleague support is found to be a valuable coping mechanism that allows nurses the chance to receive emotional support and validation of their feelings, which reduces their perceived stress levels (Cameron and Brownie, 2010). Additionally, peer support contributes to greater resilience and reduced depression, in nurses experiencing workplace violence (Hsieh et al, 2016). The support from colleagues also promotes constructive role modelling and lessens impacts of adverse events (Pfeiffer et al, 2011). Findings from this study, supported by the literature appears to suggest that collegiality has a positive influence on the workplace environment, which in turn impacts upon the practice environment.

This study has identified the need to actively support nurses, to allow them to provide patient centred care in a safe and nurturing environment. A supportive measure, designed to provide a more positive environment to reduce stress, and improve resilience and retention is clinical supervision (CQC, 2013c). Clinical supervision was widely available some ten years ago, but anecdotally has proved difficult to access more recently. Wide-scale research undertaken by Gonge and Buus (2011) in the mental health setting found that clinical supervision increased job satisfaction and reduced stress and emotional exhaustion. The RCN (2017a) advocates that clinical supervision as an activity to improve patient care and develop nurses' skills and knowledge. Although clinical supervision cannot be considered the 'magic bullet' to address all issues in nursing, if orchestrated within a systemic framework, by effectively trained supervisors, it may provide much needed support to nurses.

From a contextual perspective, clinical supervision was introduced in 1993 (DH, 1993) as a form of support for nurses, where facilitated groups could discuss clinical and professional issues in a structured way. Clinical supervision is endorsed as being an essential support in nursing practice by the Care Quality Commission (2013). The purpose of these exercises was to help the nurse to reflect upon experiences in

practice and in doing so learn and develop. The following definition of clinical supervision is provided by the RCN (2017a):

“Clinical supervision is an activity that brings skilled supervisors and practitioners together in order to reflect upon their practice. It is a time for you, as a nurse or midwife, to think about your knowledge and skills and how they may be developed to improve care. It has been described as providing education for the nurse and protection for the client” (RCN, 2017a)

The concept advocates that groups are run in a supportive, non-judgemental and confidential environment and encourages practitioners to discuss challenges they are faced with (RCN, 2017a). Reflecting upon my own experience of clinical supervision, I found the sessions valuable, as I would hear others discussing clinical issues, which served to remove the sense of isolation I sometimes felt and would give new perspectives on how to deal with situations. It reminds me of John’s (2003) method of guided reflection, which propositions practitioners to look at habitual practice, ‘the way we have always done it’, and look if there’s a different, better way of doing that practice. Certainly, the ethos of clinical supervision could be implemented as a form of learning, when incidents occur, removing the notion of blame. From a resilience perspective, learning is gained through the challenges that have been experienced, that can be perceived as personal growth (McAllister and Lowe, 2011). The success of clinical supervision relies on expert facilitation as it could easily become a moaning session, or indeed a managerial policing exercise which would culminate in low morale and mistrust. Critics also suggest that ineffectively run clinical supervision sessions can be harmful to nurses, with the potential to breach confidentiality and manifest bullying behaviours. (Yip, 2006; Ecclestone and Hayes, 2009). A comparative study carried out in Portugal and the UK by Abreu and Marrow (2013) found that UK participants, were constrained by time, understanding and commitment in accessing clinical supervision. A systematic review by Butterworth *et al* (2008) found that, although clinical supervision was considered an embedded practice in the UK, levels of engagement varied widely between 18% and 85.9% in different locations in the UK. Frequency of clinical supervision also varied between fortnightly to annually (Butterworth *et al*, 2008). However, Breen and Sweeney (2013) found that the

presence of clinical supervision, mentoring support and teamwork created a more positive environment, and fostered resilience in nursing.

In the social care setting, professional supervision is considered the foundation of good social work (Laming, 2009) by encouraging practitioners to discuss problems, and difficulties, and apply theory and research to practice (Carpenter et al, 2017). Supervision also affords practitioners opportunities for emotional support in demanding and stressful situations (Carpenter et al, 2017). Moving forward in an integrated model of health and social care, professional supervision would afford individuals from all disciplines a supportive pathway to improve practice and build resilience into their service delivery. Taking the ethos from social care, nursing could benefit from the supervision process that values role modelling and seeks to support social workers to make ethical decisions, to enhance care delivery (British Association of Social Workers, 2011).

The data from this study suggests that participants would have benefitted from feeling more valued, and more connected to decision making and service development. A possible way to improve the practice environment and increase staff engagement, would be the establishment of communities of practice. Communities of practice is a model of situated learning, based upon the work of Lave and Wenger (1991). The ethos of this approach is to integrate research into practice, using the collaborative working of clinicians, service providers and academic staff. By integrating and disseminating research evidence into the practice environment, learning becomes contextually based and therefore has greater relevance. The success of communities of practice largely depend upon the relationships that exist or are created for this purpose, both within and outside the group, and the group having the shared vision and value of the activity (Lathlean and Le May, 2002). Nursing has become familiar in practicing in collaborative ways, with other members of the multi-disciplinary group to better manage patient care delivery. Indeed, as Health and Social Care integrate services, collaborative working is of greater priority than ever before. Therefore there is much potential within the nursing community itself and in the joint partnerships already existing to utilise the notion of communities of practice to learn and develop in a collective manner. As the group acquires, consolidates and shares knowledge, learnt through participation, then the desired outcome can result in shared practice, more

insightful relationships and mutual respect (Ranmuthugala et al, 2011). Indeed, Le May (2009) asserts that standards of practice improve as knowledge and learning increase. Certainly, the theory practice gap, remains a significant problem in nursing, with a requirement for clinical practitioners to forge alliances with researchers and academics to create a fusion of knowledge, with practical application (Korthagen, 2007). It seems reasonable therefore to assume that the utilisation of communities of practice in the NHS would be an advantageous addition, which would serve to foster new relationships within the nursing community with its partners in service provision and academia. If practitioners could be given the environment to engage in collaborative partnerships with education, social care, and the wider multi-disciplinary membership, care standards would improve, along with morale and retention.

Heidegger's (1927/2010) work has bearing upon this discussion in several ways. Throughout this study, participants have voiced their concerns, frustrations and anger, yet also their abiding concern for their patients and their peers. Through this valuable *discourse* Heidegger reminds us of the importance of talking and listening. Heidegger (1927/2010) also speaks about interactions with others, in *being-with* (*Mitsein*). He urges us to look at the influences that others have upon our *Being*, since our *authenticity* is dependent upon our recognising other people's influence upon us. Through and within these various discussions is Heidegger's (1927/2010) insistence that we must free ourselves from the '*thrownness*' of life, and pay attention to our *temporality* on earth. He posits that when we realise that we are always close to death, in the phrase *Being-towards-death* (*Sein-zum-Tode*), where death is depicted as *nothingness* (*das Nichts*), then we may start to uncover our own *authenticity*. Whilst we are absorbed with our everyday work and only hear the '*chatter*' of the world we adopt a *they-self*, in many ways lost from ourselves. Heidegger (1927/2010) suggests that in order to see things differently, we must step back and stop, consider our *temporality* and notice the world. In this very realisation that others cannot save us from death, and in death we are alone, Heidegger (1927/2010) believes this would stop us from worrying about other people's opinions and the need to seek others' approval for our actions. However, Heidegger (1927/2010) also explores our selfishness to others, when because we are absorbed in *the they-self*, we can without meaning to, treat others like we do equipment, as if they were tools, rather than individual *Beings*. Heidegger (1927/2010) advises that in order to remedy this lack of

thought for others we step back from ourselves and stop to notice others *being-in-the-world*.

This study adds new insights to the existing body of knowledge, in relation to how nurses perceive and emotionally cope with the complex and often challenging role of nursing. Findings are used to offer discussion with regards to how nurses can be better supported in the practice environment. The participants describe how their professional accountability was frequently compromised through inadequate resources. It was clear that their steadfast determination to provide high quality care was a driving force in their aspirations in nursing and adds to the theory of resilience. Findings suggest that a positive working environment, with positive collegial support was beneficial to all participants, a fact that was reflected in the literature. Participants viewed collegiality as a major factor that gave them the strength to carry on, in difficult times, and was clearly part of their ability to cope. When management was seen as remote or ineffective, collegiality became a huge support mechanism. The literature gives powerful testimony to the effects of collegiality upon job satisfaction and retention, but also notably on its effects upon patient care. Building resilience in nursing appears to be of critical importance at this challenging time, and therefore a supportive approach is vital. To enhance the culture of nursing, making a positive environment for practice will foster collegiality. I suggest that this would be achieved through effective management and leadership and the availability of regular professional supervision to support and nurture development. I have also made mention of the establishment of communities of practice, not only to value and engage staff, but also to integrate research into the practice environment. Having drawn together the findings from this study, chapter eight will present recommendations.

Chapter Eight: Recommendations

Overview

This final chapter offers recommendations for policy, practice, education and research that have been driven by the findings from this study. These recommendations are grounded in research and the Heideggerian influences that have underpinned this study. The recommendations reiterate the need for a positive practice environment facilitated through education and leadership. By establishing adequate staffing levels, and ensuring changes to governance, nurses will be able to fulfil their ideals of professional accountability. This chapter further details how these theoretical recommendations could be applied in practice, and how the combined effects could impact upon the retention, resilience and recruitment of nurses. The chapter concludes by looking at the limitations of this study, and describes the dissemination of this work, before offering some closing remarks. The essence of this chapter involves looking forward, equipped with the knowledge of the past to see the future of nursing and its *potentiality*.

Introduction

In an endeavour to contextualise the past and present situation of the nursing profession, I would now like to look forward to visualising the possible constructs for its future development. As nursing faces the future, with challenges to its retention and recruitment, in an NHS free at the point of access that is struggling to deliver quality care, the solutions need to be innovative and creative. Lessons have to be learnt from past failings, and systems need to be modified to work in collaboration with social care settings. It seems that the possible solutions are already available but need to be embedded within the new service provision arena. Nursing is a unique profession, with an exceptional breadth of opportunity. Careers in nursing can range from staff nurse to nurse consultants, with opportunities in academia, management and industry. It is a profession that should not be shackled by oppression, but instead embrace its diversity and the potential power from the wealth of talent and sheer numbers of its registrants. Nursing has the potential to have a very audible voice in service redesign and infrastructure. However, nursing needs to have strong role models and effective

management and leadership for this to be realised. Indeed, considering there is a registrant body of 690,773 nurses in the UK (NMC, 2017a), there is immense potential to instigate change.

Although it is beyond the remit of this thesis to debate changes in pedagogic approaches in the UK, it acknowledges that changes to practice learning may be on the horizon following the Willis review (2015), and the recent report from the Council of Deans of Health (CoDH, 2016). These reports both emphasise the need to improve the practice learning environment, and the quality of practice learning for pre-registration nurses. The current draft consultation by the NMC (2017c) proposes the adoption of a new framework entitled the *Five pillars for education and training*, which redefines proficiency standards for education and clinical practice. If approved, the new framework will be implemented in September 2019 (NMC, 2017c). The introduction of associate nurses was a recommendation of the Willis review (2015) and will see a new registered support role that is positioned between care assistants and registered nurses (HEE, 2016). Furthermore, the introduction of apprentice degree nurses introduced in September 2017 (DH, 2017) signals a move in pre-registration nurse education reminiscent of post Project 2000 training. The idea of nurse coaches being released from clinical duties, and working alongside educators and mentors to deliver collaborative learning in practice (Willis review, 2015) is a commendable idea, but would require considerable investment in workforce planning.

Therefore, with reference to the changes that may be on the horizon for nurse education, this thesis offers a wealth of transformative measures. This study pertains to the improvement of the practice environment by making the culture of nursing a positive one, which seeks to afford both pre- and post-registered nurses a safe learning environment. In Heideggerian terms, nursing needs a safe *dwelling* place to develop and nurture practice and development. A positive culture would enhance collegiality and increase resilience, affording retention of qualified nurses and increasing recruitment of future nurses. Study findings demonstrate that the ethos of professional socialisation and occupational values must undergo positive steps forward, in valuing the dedication and hard work of colleagues and the creation of a supportive culture that encourages openness. Communities of practice would positively impact the clinical practice setting, utilising collaborative working whilst

embedding research into practice and improving standards. The concept of utilising communities of practice has been embraced by the business arena for decades but not widely used in healthcare settings, despite its obvious potential (Li et al, 2009). The value of communities of practice to the business sector was seen as a driver for innovation and knowledge management, whilst serving as a vehicle to teach new staff and create social capital as well as adding organisational value (Lesser and Storck, 2001). The benefits of using a communities of practice approach in nursing lies in the prospect of being able to disseminate and integrate research evidence into practice and allowing practitioners to put learning into the context of the practice environment.

Recommendations

The recommendations of this study are divided into four sections, covering policy, practice, education and research. Although I have made this division, many of the recommendations intersect with one another. However, the main changes to the cultural environment needs to come from within the nursing profession, which will hopefully be shaped and guided by policy and education. The findings depict a negative organisational culture that is fuelled by blame and results in anxiety, fear and a reticence to raise concerns. This study, supported by the available literature, conceives that a negative practice environment is not conducive to learning, civility or professional development, and has adverse effects on patient care. Nurses need to feel valued and supported by adequate resources, effective management and leadership, alongside robust operational systems. It is these fundamental provisions in healthcare that the following recommendations address. Table 6 provides a summary of the recommendations of this study, showing links to findings, Heideggerian concepts and the NHS.

Table 6: Showing conceptualisation of recommendations, in relation to policy, practice, education and research

| Section | Recommendation | Relationship to study findings | Practical application of theory to practice in NHS |
|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Policy | Changes to management/leadership Links to Heidegger's (1927/2010) notion of <i>solicitude</i> Changes to governance Adequate staffing levels | Management considered remote/inaccessible Lack of leadership Participants' experienced feelings of being unvalued Negative practice environment Incivility Retention/recruitment Poor governance Ineffective reporting system High workloads creating stress/burnout | Adequate staffing Changes to governance/reporting systems Shared governance/inclusion initiatives Management training Listening exercises to seek staff views and experiences Team building/away-days/development days Engagement exercises |
| Practice | Creating a positive culture Links to Heideggerian philosophy relating to notion of coping, <i>dwelling</i> | Negative practice environment Lack of effective management/leadership Incivility Retention Resilience Theory/practice gap Emotional costs of nursing | Access to professional supervision Communities of practice Mentorship/buddying systems |
| Education | Teaching and guidance on emotional intelligence Links to Heideggerian philosophy, relating to <i>worldhood, dwelling, discourse and care</i> | Fear experienced in unready-to-hand situations Negative practice environment Professional socialisation Incivility Emotional costs of nursing Retention | Mentorship/buddying systems Use of reflective practice Attention to the theory/practice gap Teaching on emotional intelligence Curriculum engagement with Heideggerian philosophy, relating to <i>worldhood, dwelling, discourse and care</i> |
| Research | Further research would include: Fear in the nurses' <i>lifeworld</i> Resilience Professional socialisation Oppression | Fear in unready-to-hand situations Resilience Incivility Professional socialisation Retention | Further qualitative research would seek to develop greater insights into the nurses' <i>lifeworld</i> , and deliver new perspectives |

Policy

Changes to management and leadership, incorporating Heidegger's (1927/2010) theories on *solicitude*, incorporating an approach that has both practical and empowering attributes.

The findings of this study articulate the need for supportive management and leadership in nursing. This notion has permeated through many of the essential concepts and as such presents itself as a pivotal issue. Participants spoke of a remote and inaccessible system of management, which negatively impacted upon the blame culture, and did not support practice or developmental needs. Findings, supported by the literature observe that effective management and leadership is essential to bring about change in the practice environment, pertaining to incivility, retention, resilience and governance. To address this issue, this study recommends changes to the management and leadership approach. Heidegger's (1927/2010) notion of *solicitude* could be incorporated into a new approach to provide practical assistance when required, combined with empowerment whilst being guided by *tolerance* and *consideration* (Heidegger 1927/2010).

Changes to the current system of governance which incorporates an effective reporting system. An approach of shared governance which values and engages staff in decision making would lay the foundations for a more positive culture.

Participants in this study raised the issue of an ineffective reporting system that did not result in any change to the clinical environment. Participants spoke of raising concerns about excessive workloads, yet despite following the appropriate channels, the process had no effect on changing the practice environment. Therefore, this study recommends changes to the current system of governance and incident reporting to encourage nurse reporting, and look for ways to avoid incidents from recurring. The approach of shared governance may provide this cultural shift in terms of shared ownership and afford nurses a feeling of being valued, with their views heard and respected. Shared governance, however, relies strongly upon effective management and leadership for its success. Although the system of shared governance is being

adopted in a few isolated hospital trusts, this needs to be a unified roll out across the NHS.

Adequate staffing levels would enable nurses to fulfil the ideals encompassed within professional accountability, affording them the opportunity to provide patient centred care.

This study's findings demonstrate that inadequate staffing levels create excessive workloads, which in turn compromise nurses' professional accountability. When staffing was reduced, participants had insufficient time to nurse and quality of care decreased; a fact that is supported by the literature. Reduced staffing impacted upon the participants' ability to provide holistic care. For the participants in this study, the ability to nurse holistically was noted as a non-negotiable issue. It was articulated that it was possible to become task orientated and appear more efficient, but this was not the kind of nursing they could personally embrace and resulted in moral distress. Recommendations from the Francis report (2013) identified the need for trusts to implement minimum staffing levels. However, this standardisation process did not encompass primary care settings, which seems a serious omission.

Practical application of theory into practice in the NHS.

In order to ground these recommendations into practice, it would be pertinent to carry out some scoping initiatives, involving listening exercises to seek staff views and experiences. Although team building, away days and development days are costly in terms of workforce planning, they would deliver considerable benefits for staff engagement, feeling valued and developing a sense of belonging. These exercises also allow frontline staff to build meaningful relationships with managers and allow managers to 'talent spot' future leaders within their own organisations. In addition, engagement exercises will assist in developing a more cohesive and positive practice environment and facilitate much needed change. If meaningful changes to governance are to be successful, inclusion initiatives such as shared governance are essential.

Practice

The establishment of a positive practice environment through effective management and leadership, and access to professional supervision.

Introducing communities of practice would serve to integrate research into practice, and thereby address the theory/practice gap.

Findings from this study demonstrate that a positive culture is needed to nurture and support safe clinical practice. In addition to the changes needed in policy, as outlined in the previous section, this study recommends that clinical supervision becomes an accessible resource. Clinical supervision has the capacity to allow nurses of all grades to engage in reflection and learning in a supportive environment in order to improve practice. Using the Heideggerian concepts of *dwelling* and *discourse*, the environment could become a safe place (*dwelling*), which nurtures and promotes development. Incorporating the idea of communities of practice would serve to incorporate research into practice, whilst fostering stronger links between clinical practice and academia. Nursing has become familiar with practising in collaborative ways with other members of the multi-disciplinary group to better manage patient care delivery. Indeed, as Health and Social Care integrate services, collaborative working is seen as a priority. Therefore, there is much potential within the nursing community itself and in the joint partnerships already existing to utilise the notion of communities of practice to learn and develop in a collective manner. Communities of practice in the NHS would be an advantageous addition that would serve to foster new relationships within the nursing community and with its partners in service provision and academia. Indeed, Le May (2009) asserts an engagement in collaborative partnerships with education, social care and the wider multi-disciplinary membership improves care standards, along with morale and retention (Ranmuthugala et al, 2011).

Practical application of theory into practice in the NHS

In order to ground these recommendations in practice, nurses need access to professional supervision, which should be facilitated by trained individuals. By reflecting upon issues and dilemmas in clinical practice with peers and colleagues, individuals feel less isolated, and are empowered to problem solve by listening to

others. Moreover, communities of practice would serve to integrate research into practice and build relationships with academic and clinical staff. Valuable outcomes from both of these measures would be that staff feel more valued and engaged with decision making. Furthermore, the use of mentorship and buddying systems have the potential to use professional socialisation in a positive manner through support and learning, allowing nurses a positive practice environment.

Education

Supportive supervision sessions with clinical staff and practice educators could demonstrate the value of discourse and reflection to support and nurture students.

This study has explored the *lifeworld* of nurses in respect of their professional accountability and found that fear was apparent in new and unfamiliar environments where individuals were faced with new rules, routines and equipment. In recognising the value of Heideggerian philosophy and understanding our methods of coping and interacting with the world, new insights and meanings can be found. Furthermore, in addressing the basic hermeneutical premise of what it means *to be*, a more ontological approach allows things to be seen differently. By engaging in meaningful *discourse* and positive mentoring, fear and distress can be pre-empted and lessened, enhancing the learning outcomes of clinical placements for students and new staff. *Discourse* in this context refers to being given opportunities to engage in meaningful conversation, talking and listening within a safe, non-judgemental environment. In this way individuals are able to learn from one another and gain new understanding of themselves and others.

Pre-registration teaching and guidance on emotional intelligence and the emotional costs of nursing. This would be beneficial in terms of coping, relationship building and resilience.

Teaching and guidance on emotional intelligence would better equip student nurses in establishing relationships with other nurses, adding to their sense of belonging and general ability to cope with the emotion-based contexts that are apparent in nursing.

With relevance to the concept of resilience, there is evidence to support the value of *discourse* as a way of managing our emotions, and of recognising our own vulnerability. Support should be readily available and include supportive supervision, mentorship and reflexive practice. Through *discourse*, we can also recognise the existence of *solicitude* as *leaping-in* and *leaping-ahead*, displayed as either problem solving or empowerment. Heidegger (1927/2010) adds a further caveat to this method of interaction, urging they be used with mindfulness as to the consequences of any such action, and a regard for the notion that *solicitude* must be guided by *tolerance* and *consideration*.

Practical application of theory into practice in the NHS

In order to ground these recommendations in practice, mentorship and buddying systems could be utilised to enhance learning and afford support to student nurses. By promoting a positive approach to professional socialisation, the practice environment would become a safer, more nurturing environment. Teaching and guidance on emotional intelligence may better prepare student nurses for coping in clinical practice, in terms of relationship building and finding a sense of belonging. Heidegger's (1927/2010) philosophy has much to add in terms of looking at our ability to cope and interact with others. His writings on *discourse* and *dwelling* are particularly helpful when discussing our emotional needs for safety within the practice environment.

Research

Further research which would be of value to future practice, thinking, research and education: Fear as experienced in the nurses' *lifeworld*, resilience in nursing, professional socialisation and oppression in nursing.

The research carried out for this thesis has emphasised a number of topics on which further research would be valuable. In terms of further exploring the everyday experience of *being* a nurse, it would be beneficial to focus on the concept of fear in the nurses' *lifeworld*. From a personal perspective, the discovery of this emotion shocked me, yet at the same time I could identify with its presence. In developing a

positive culture and more positive socialisation process in nursing, the significance and importance of this emotion in the nurses' *lifeworld* needs further exploration.

Another issue I feel would be valuable to explore, lies in the concept of resilience. When researching the literature pertaining to resilience, the issue of vulnerability was uncovered. I acknowledge the importance of resilience in nursing yet suspect that for nurses who fail to achieve it, there could be feelings of failure. I therefore suggest this may be an interesting area for further research. By utilising a Heideggerian hermeneutical approach, resilience may be seen differently in a unique and sensitive way.

Whilst engaged in researching the literature, I have been fascinated by the concept of professional socialisation, and its links to oppression in nursing. Freire's (1970) seminal work on oppression concluded that the answer to ending oppression must be driven from within the group itself, by introspection, education and enlightenment. However, oppression theory continues to be cited in contemporary literature in relation to incivility in nursing (Mikaelian and Stanley, 2016) and resilience work (McAllister and Lowe, 2011). This would be an interesting topic for further research, allowing insights through a Heideggerian lens.

Practical application of theory to practice in the NHS

By engaging in further research in the areas indicated, there is a very real possibility that greater insights may be uncovered into the nurses' *lifeworld*. Certainly, the phenomenon of fear being present in the nurses' *lifeworld* is an area that does not appear to have received attention in the literature, so would make for a unique study. It would also be of value to see resilience from a different perspective, and explore whether this phenomenon has a negative facet.

Limitations of this study

Critics may argue this study could have benefitted from involving more participants. However, considering its phenomenological roots, the emphasis has always been in the richness and depth of the data; therefore, having fewer participants becomes its strength. I have also contemplated whether potential participants were reluctant to

come forward, given the contentious nature of the study, in asking them to discuss their experiences of professional accountability.

From a Heideggerian hermeneutical standpoint, I began this journey as a novice researcher, and made decisions based upon my existing knowledge and experience. The knowledge and experience I have gained, especially into Heidegger's (1927/2010) work, has made me question my interview process. With hindsight I feel I made the mistake of asking a direct question relating to the blame culture of the NHS. The question I posed allowed ambiguity, but more importantly directed participants' answers in a certain direction. I now feel I should have allowed the participants the option of telling me about their experiences of culture, without my influence.

Through this reflexive process, my own thoughts and ideas surrounding nursing have changed. I came to the research process as a clinical nurse practitioner, with a somewhat cynical perspective of nursing borne from my own experience of nursing and the adversity I had encountered. My negative perspectives at the outset of this study had the potential to cloud my judgement and give a negative interpretation of the participants' experience. The process of reflecting upon my own *fore-structures* and the value of keeping a reflective journal alongside supervisory support, allowed me clarity so my interpretations remained visible yet separate.

Because the participants were recruited via continuing professional development (CPD) at Manchester Metropolitan University, the workplaces were not localised within one hospital trust, which allowed for diversity in experience. Moreover, I feel my own experience of nursing, and the fact that I could relate to comments and stories, allowed a sense of trust and openness to be revealed.

Dissemination

This research project will be used in a scholarly capacity to add to the practical, policy and theoretical bodies of knowledge, through peer reviewed articles and seminar presentations. It will also have professional impact in informing practice, policy and education to support nurses.

It is hoped that by the clear explanations of Heidegger's (1927/2010) work, theories and use of vocabulary other researchers may be able to use this philosophy in nursing research.

The findings of this study will utilise contemporary media applications to allow dissemination to a wider audience. Towards the end of the research process I decided to post blogs concerning the philosophy of Heidegger (1927/2010), which can be viewed online (<https://being-in-the-world.org/>). This method of dissemination was selected, not for any narcissistic reason but for the satisfaction of being able to use the immense amount of reading and learning I have undertaken to help others. When put into plain English, the concepts of Heideggerian phenomenology are understandable and in turn useful, especially for nurses. Having a consistent, and yet transient audience from blogging has made this a very enjoyable and enriching experience as there is an element of instant gratification knowing that someone else has found it useful to their learning. Blogging is a highly accessible method of communication, which spans generations, educational divides and class systems. Knowing also that my thesis will be freely available online is also gratifying as historically a doctoral thesis would only be seen by other students attending the same university. Now they are all readily available to view via websites, offering a wealth of previously unseen literature. I am also in the process of recording a You-tube video and web-cast to showcase the work of Heidegger (1927/2010), again using a plain English format approach to aid others' understanding. The Research Councils UK (RCUK, 2017) describes the impact of research as 'the demonstrable contribution that excellent research makes to society and the economy'. Research impact covers the influence it has across the arenas of academia and the effects it can have on socio-economic climates.

Personal learning

This study has had a profound personal impact through my own academic journey, enriching my knowledge, learning new research skills and challenging my own preunderstandings relating to professional accountability and nursing generally. Undoubtedly, the most challenging area of the research process has been managing the feelings, which the interview's uncovered. I was unprepared for the raw emotion which participants brought to the study, and the reactions which it manifested in

myself. Memories of incidents that I had not thought of in decades came flooding back, along with the sadness, happiness, frustration or anger which were rooted to them. Nobody could have prepared me for this, but its occurrence allowed me to reflect on my own emotions, and thoughts, before returning to the hermeneutic circle, with new interpretations. I note how my stance as a researcher changed from inquirer, to confidante, peer, and at certain points mother. The experience has been difficult at times, taking paths which were new, learning from trial and error and constantly reappraising and rewriting. In all it has been a journey of self-discovery, making me look at myself, my past, present and potentiality of *being*.

Concluding remarks

This study has explored the premise of *being* a nurse, using the philosophy of Heidegger (1927/2010). It has acknowledged the importance of understanding the individual and cumulative experiences of nursing as a dynamic and changing profession: from the new student nurse, unfamiliar with the historical practices and socially constructed norms of the nurses' environment (*Umwelt*); to the dissimilarities of practice from one clinical area to another; or conflicts between primary and acute care. The *being of being* a nurse is a socially constructed entity, which is complex and veiled, under the cover of the *everydayness* of culture and historicity. By exploring thoughts, feelings and values, the study has revealed important insights illuminated by the philosophy of Heidegger (1927/2010). Furthermore, by undertaking a Heideggerian hermeneutical approach it has allowed me, as the researcher, to be part of the research process. By using this approach my own experience of *being* a nurse could be unified with the participants' and allowed a transparent interpretive process to be realised.

In closing, I would like to reflect upon the contribution that Heidegger's (1927/2010) work has made to this study. Heidegger (1927/2010) is fundamentally a teacher. His philosophy essentially unveils concepts relating to the way we live and interact with the world. It has been useful to examine individuals' coping mechanisms, and consequentially consider meaningful support in order to achieve a more fluid process of interaction. Often the very acknowledgement that these challenges exist, and that individuals will ultimately lack the prior knowledge and skills necessary to navigate

certain situations will reduce anxiety and help learning to take place. Indeed, the most beneficial learning in nursing practice is often unplanned and relies on astute facilitation to recognise the situation as a learning opportunity (Morley, 2015). Therefore, support in practice and positive role modelling is vital and can produce a nurturing platform for growth for all parties. Heidegger's (1927/2010) work pertaining to the concept of the care structure was utilised in relation to our *being-with* others, and was also incorporated into thoughts on nursing care and the management process. Perhaps Heidegger's (1927/2010) thoughts on *authenticity* are particularly useful as a final observation, as he reminds us of the possibilities of *being*, in fulfilling our own potential.

This potentiality is that for the sake of which any Dasein is as it is. Dasein has already compared itself, in its being, with a possibility of itself.

Heidegger (1927/2010:192)

I suggest that if nursing realises its own potential, through strong role models and effective management and leadership, it has the capacity to demonstrate an audible voice in service redesign and infrastructure. By establishing a positive practice environment, which nurtures and supports staff, its registrant body of 690,773 nurses in the UK (NMC, 2017a) has vast potential to instigate change.

References

Ablett, J. R. (2007) *Resilience and well-being in palliative care staff: a qualitative study of hospice nurses' experience of work*. Publisher details not available. [Online] [Accessed on 21st July 2017] <http://e.bangor.ac.uk/4385/1/434889.pdf>

Abreu, W. J. C. P. and Marrow, C. E. (2013) 'Clinical supervision in nursing practice: a comparative study in Portugal and the United Kingdom.' *SANARE*, 11(2), pp.16-24. [Online] [Accessed on 28th May 2017] <https://sanare.emnuvens.com.br/sanare/article/download/285/255>

Academy of Medical Royal Colleges. (2014) *A Charter for Postgraduate Medical Training: value of the Doctor in training*. London: Academy of Medical Royal Colleges. [Online] [Accessed on 1st January 2017] https://www.aomrc.org.uk/wp-content/uploads/2016/05/Value_of_the_Doctor_in_Training_Charter_0414.pdf

Academy of Medical Royal Colleges. (2016) *Creating supportive environments: tackling behaviours that undermine a culture of safety*. London: Academy of Medical Royal Colleges [Online] [Accessed on 3rd January 2017] http://www.aomrc.org.uk/wp-content/uploads/2016/09/Creating_supportive_environments_280916-2.pdf

Aiken, L. H., Clarke, S. P., Sloane, D. M., Lake, E. T. and Cheney, T. (2008) 'Effects of hospital care environment on patient mortality and nurse outcomes.' *Journal of Nursing Administration*, 38(5), pp. 223-229.
DOI:10.1097/01.NNA.0000312773.42352.d7

Aiken, L. H., Sloane, D. M., Bruyneel, L., Van den Heede, K., Griffiths, P. and Busse, R. (2014) 'Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study.' *Lancet*, 383(9931), pp.1824-1830. [Online] [Accessed on 9th January 2017] DOI: [http://doi.org/10.1016/S0140-6736\(13\)62631-8](http://doi.org/10.1016/S0140-6736(13)62631-8)

- Aiken, L. H., Sloane, D. M., Griffiths, P., Rafferty, A. M., Bruyneel, L., McHugh, M., Maier, C. B., Moreno-Casbas, T., Ball, J. E., Ausserhofer, D. and Sermeus, W. (2016) 'Nursing skill mix in European hospitals: cross-sectional study of the association with mortality, patient ratings, and quality of care.' *British Medical Journal Quality & Safety*. [Online] Online first published 15th November 2016. [Accessed on 23rd May 2017] DOI: 10.1136/bmjqs-2016-005567
- Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J. and Silber, J. H. (2002) 'Hospital nurse staffing and patient mortality, nurse burnout and job dissatisfaction.' *Journal of the American Medical Association*, 288(16), pp.1987-1993.
- Akerjordet, K. and Severinsson, E. (2008) 'Emotionally intelligent nurse leadership: a literature review study.' *Journal of Nursing Management*, 16(5), pp. 565-577. [Online] [Accessed on 12th October 2017] <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2834.2008.00893.x/full>
- Ajjawi, R. and Higgs, J. (2007) 'Using hermeneutic phenomenology to investigate how experienced practitioners learn to communicate clinical reasoning.' *The Qualitative Report*, 12, 6, pp. 612-638. [Online] [Accessed on 13th September 2016] <http://nsuworks.nova.edu/cgi/viewcontent.cgi?article=1616&context=tqr>
- Alvesson, M. (2012) *Understanding organizational culture*. London: SAGE Publications.
- Alvesson, M. and Sköldberg, K. (2009) *Reflexive methodology: new vistas for qualitative research*. London: SAGE Publications.
- Andrews, S. (1996) 'Lexical retrieval and selection processes: effects of transposed-letter confusability.' *Journal of Memory and Language*, 35(6), pp. 775-800.
- Annells, M. (1996) 'Hermeneutic phenomenology: philosophical perspectives and current use in nursing research.' *Journal of Advanced Nursing*, 23(4), pp. 705-713.
- Antle-May, K. (1991) 'Interview techniques in qualitative research.' In Morse, J. M. (ed.), *Qualitative nursing research: a contemporary dialogue*. London: SAGE Publications, pp. 187-201.

Arendt, H. (1971) 'Thinking and moral considerations: a lecture.' *Social Research*, 38(3), pp. 417-446. [Online] [Accessed on 9th February 2017]
<http://search.proquest.com.ezproxy.mmu.ac.uk/docview/1297189663?accountid=12507>

Armstrong, M. (2012) *Armstrong's handbook of management and leadership: developing effective people skills for better leadership and management*. 3rd ed., London: Kogan Page.

Armstrong, M. (2016) *Armstrong's handbook of management and leadership for HR*. London: Kogan Page.

Attree, M. (2007). Factors influencing nurses' decisions to raise concerns about care quality. *Journal of Nursing Management*, 15(4), 392-402. [Online] [Accessed on 5th March 2017] <https://doi.org/10.1111/j.1365-2834.2007.00679.x>

Austin, E. J., Dore, T. C. and O'Donovan, K. M. (2008) 'Associations of personality and emotional intelligence with display rule perceptions and emotional labour.' *Personality and Individual Differences*, 44(3), pp. 679-688. [Online] [Accessed on 12th October 2017]
http://www.research.ed.ac.uk/portal/files/14842130/Associations_of_personality_and_emotional_intelligence_with_display_rule_perceptions_and_emotional_labour.pdf

Aveyard, H. (2014). *Doing a literature review in health and social care: A practical guide*. McGraw-Hill Education (UK).

Ayre, T. C., Gerdtz, M. F., Parker, J. and Nelson, S. (2007) 'Nursing skill mix and outcomes: a Singapore perspective.' *International Nursing Review*, 54(1), pp. 56-62. [Online] [Accessed on 16th June 2017] DOI: 10.1111/j.1466-7657.2007.00518.x

Balding, C. (2008) 'From quality assurance to clinical governance.' *Australian Health Review*, 32(3), pp. 383-391. [Online] [Accessed on 20th June 2017]
http://go.galegroup.com.ezproxy.mmu.ac.uk/ps/i.do?p=AONE&u=mmucal5&id=GAL_E|A182815466&v=2.1&it=r&sid=summon&authCount=1

Bandman, E. L., and Bandman, B. (1985). *Nursing ethics in the life span*. Norwalk, Connecticut: Appleton-Century-Crofts

- Bandura, A. (2006) 'Toward a psychology of human agency.' *Perspectives on Psychological Science*, 1(2), pp. 164-180. [Online] [Accessed on 9th January 2017] <http://www.uky.edu/~eushe2/Bandura/Bandura2006PPS.pdf>
- Barden, A. M., Griffin, M. T. Q., Donahue, M. and Fitzpatrick, J. J. (2011) 'Shared governance and empowerment in registered nurses working in a hospital setting.' *Nursing Administration Quarterly*, 35(3), pp. 212-218.
- Bassett, S. and Westmore, K. (2012) 'How nurse leaders can foster a climate of good governance.' *Nursing Management*, 19(5), pp. 22-24 [Online] [Accessed on 3rd January 2017] <http://journals.rcni.com/doi/pdfplus/10.7748/nm2012.09.19.5.22.c9261>
- Bauman, Z. (1978) *Hermeneutics and Social Sciences: approaches to understanding*. London: Hutchinson.
- Bazerman, M. H. and Tenbrunsel, A. E. (2011) *Ethical breakdowns*. April. *Harvard Business Review*. [Online] [Accessed on 3rd January 2017] tinyurl.com/br2w5w9
- Beauchamp, T. L. and Childress, J. F. (2001) *Principles of biomedical ethics*. 5th ed., Oxford: Oxford University Press.
- Becher, J. and Visovsky, C. (2012) 'Horizontal violence in nursing.' *Medical and Surgical Nursing*, 21(4), pp. 210-213. [Online] [Accessed on 7th October 2017] <http://go.galegroup.com.ezproxy.mmu.ac.uk/ps/i.do?ty=as&v=2.1&u=mmucal5&it=DI&url&s=RELEVANCE&p=AONE&qt=TI~%22Horizontal%20Violence%20in%20Nursing%22~~SP~210~~IU~4~~SN~1092-0811~~VO~21&lm=&sw=w&authCount=1>
- Beer, G. (2013) Too posh to wash? Reflections on the future of nursing. 28th January. 2020health. [Online] [Accessed on 27th November 2017] <http://www.2020health.org/2020health/Publications/Publications-2013/Too-posh-to-wash.html>
- Begley, C.M. and White, P. (2003) 'Irish nursing students' changing self-esteem and fear of negative evaluation during their preregistration programme.' *Journal of Advanced Nursing*, 42(4), pp. 390-401. [Online] [Accessed on 11th November 2016] DOI: 10.1046/j.1365-2648.2003.02631.x <http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.2003.02631.x/full>

Bell, S. K., Delbanco, T., Anderson-Shaw, L., McDonald, T. B. and Gallagher T. H. (2011) 'Accountability for medical error: moving beyond blame to advocacy.' *CHEST*, 140(2), pp. 519-526. [Online] [Accessed on 14th December 2016]

[http://journal.chestnet.org/article/S0012-3692\(11\)60430-3/fulltext](http://journal.chestnet.org/article/S0012-3692(11)60430-3/fulltext)

Benner, P. (1985) 'Quality of life: A phenomenological perspective on explanation, prediction and understanding in nursing science.' *Advances in Nursing Science*, 8(1), pp. 1-14. [Online] [Accessed on 28th June 2016]

http://journals.lww.com/advancesinnursingscience/Abstract/1985/10000/Quality_of_life_a_phenomenological_perspective_on.4.aspx

Benner, P. (1994) *Interpretive phenomenology: embodiment, caring, and ethics in health and illness*. London: SAGE Publications.

Berwick, D. (2013) *A promise to learn – a commitment to act: improving the safety of patients in England*. Unknown place of publication: National Advisory Group on the Safety of Patients in England. [Online] [Accessed on 18th March 2015]

<https://www.gov.uk/government/publications/berwick-review-into-patient-safety>

Birkinshaw, J. (2010) *An experiment in reinvention*. People Management. [Online] [Accessed on 3rd January 2017]

http://www.forevueinternational.com/Content/sites/forevue/pages/1405/8_1_9_Management_An_Experiment_in_Reinvention.PDF

Birks, M., and Mills, J. (2015). *Grounded theory: A practical guide*. Sage.

Blenkinsopp, J. and Snowden, N. (2016) 'What about leadership? Comment on "Cultures of Silence and Cultures of Voice: The Role of Whistleblowing in Healthcare Organisations."' *International Journal of Health Policy and Management*, 5(2), pp. 125-127. [Online] [Accessed on 11th October 2017]

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4737538/>

Boell S. K. and Cecez-Kecmanovic, D. (2010) 'Literature reviews and the hermeneutic circle.' *Australian Academic and Research Libraries*, 41(2), pp. 129-144. [Online] Preprint [Accessed on 4th April 2016] http://www.xn--blls-5qa.de/publications/2010_AARL-Boell,Cecez-Kecmanovic-Literature_Reviews_and_the_hermneutic_circle_preprint.pdf

Bolam v. Friern Hospital Management Committee (1957) 1 WLR

Bolitho v. City and Hackney Health Authority (1997) 4 All ER 771

Bontekoe, R. (1996) *Dimensions of the hermeneutic circle*. Atlantic Highlands, NJ: Humanities Press International.

Boven, M. (2005) 'Public accountability.' In Ferlie, E., Lynn, L. E. and Pollitt, C. (eds.) *The Oxford handbook of public management*. Oxford: Oxford University Press.

Boyd, C.O. (2001). Phenomenology the method. In P.L. Munhall (Ed.), *Nursing research: A qualitative perspective* (3rd. ed., pp. 93-122). Sudbury, MA: Jones and Bartlett.

Boykin, A., Schoenhofer, S., Smith, N., St Jean, J. and Aleman, D. (2003) 'Transforming practice using a caring-based nursing model.' *Nursing Administration Quarterly*, 27(3), pp. 223-230.

Branch, S., Ramsay, S. and Barker, M. (2013) 'Workplace bullying, mobbing and general harassment: a review.' *International Journal of Management Reviews*, 15(3), pp. 280-299. [Online] [Accessed on 25th June 2017] http://www.sc.edu/ombuds/doc/Branch_Ramsay_and_Barker_2013.pdf

Braithwaite, J., Hyde, P. and Pope, C. (2010) *Culture and climate in healthcare organizations*. Basingstoke: Palgrave Macmillan.

Breen, M. and Sweeney, J. (2013) 'Burnout: the experiences of nurses who work in inner city areas.' *Mental Health Practice*, 17(2), pp. 12-20. [Online] [Accessed on 12th October 2017] <https://journals.rcni.com/doi/full/10.7748/mhp2013.10.17.2.12.e850>

Brentano, F. (1874) *Psychology from an empirical standpoint*. Kraus, O. (ed.) Translated by A. C. Rancurello, D. B. Terrell, and L. L. McAlister, 1995. 2nd ed., London: Routledge.

British Association of Social Workers. (2011) *UK Supervision Policy*. Birmingham: British Association of Social Workers. [Online] [Accessed on 24th July 2017] http://cdn.basw.co.uk/upload/basw_73346-6.pdf

Brocki, J. and Wearden, A. (2006) 'A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology.' *Psychology and Health*, 21(1), pp. 87-108. [Online] [Accessed on 1st June 2016] <http://www.tandfonline.com/doi/pdf/10.1080/14768320500230185?instName=Manchester+Metropolitan+University>

Brotheridge, C. M. and Lee, R. T. (2003) 'Development and validation of the Emotional Labour Scale.' *Journal of Occupational and Organisational Psychology*, 76(3), pp. 365-379. [Online] [Accessed on 19th August 2017] <http://onlinelibrary.wiley.com/doi/10.1348/096317903769647229/epdf>

Bunkers, S. S. (2012) 'The lived experience of feeling disappointed: a parse research method study.' *Nursing Science Quarterly*, 25(1), pp.53-61. [Online] [Accessed on 3rd July 2016] <http://journals.sagepub.com/doi/pdf/10.1177/0894318411429063>

Burke-Draucker, C. (1999) 'The critique of Heideggerian hermeneutical nursing research.' *Journal of Advanced Nursing*, 30(2), pp. 360-373. DOI: 10.1046/j.1365-2648.1999.01091.x

Burke-Draucker, C., Martsof, D. S. and Poole, C. (2009) 'Developing distress protocols for research on sensitive topics.' *Archives of Psychiatric Nursing*, 23(5), pp. 343-350. [Online] [Accessed on 5th January 2018] <https://pdfs.semanticscholar.org/18ef/19a033e1be6f4f0ecd75aed187ce4da24519.pdf>

Butterworth, T., Bell, L., Jackson, C. and Majda, P. (2008) 'Wicked spell or magic bullet? A review of the clinical supervision literature 2001–2007.' *Nurse Education Today*, 28(3), pp. 264-272. [Online] [Accessed on 25th November 2016]

[http://www.supervisionandcoaching.com/pdf/page2/Butterworth%20et.al%20\(2008\)%20CS%20Lit%20Review%202001%20-%202007.pdf](http://www.supervisionandcoaching.com/pdf/page2/Butterworth%20et.al%20(2008)%20CS%20Lit%20Review%202001%20-%202007.pdf)

Butterworth, T., Faugier, J. and Burnard, P. (1998) *Clinical supervision and mentorship*. 2nd ed., London: Stanley Thornes.

Calman, K. (1994) 'The profession of medicine.' *British Medical Journal*, 309, pp. 1140-1143. [Online] [Accessed on 1st November 2014]

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2541936/pdf/bmj00463-0046.pdf>

Cameron, F. and Brownie, S. (2010) 'Enhancing resilience in registered aged care nurses.' *Australasian Journal on Ageing*, 29(2), pp. 66-71. [Online] [Accessed on 21st July 2017]

<http://onlinelibrary.wiley.com/doi/10.1111/j.1741-6612.2009.00416.x/full>

Campbell, R. (2001) 'Heidegger: truth as Aletheia.' In Small, R. (ed.) *A hundred years of phenomenology: perspectives on a philosophical tradition*. Burlington, VT: Ashgate, pp. 73-89.

Care Act 2014. (c. 23) London: TSO. [Online] [Accessed on 30th September 2017]

http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf

Care Quality Commission. (2009) *Supporting briefing note: issues highlighted by the 2009 NHS staff survey in England*. Publisher details not available. [Online]

[Accessed on 6th February 2017]

http://www.nhssurveys.org/Filestore/documents/MH_Inpatient_Key_Findings.pdf

Care Quality Commission. (2013a) *Putting people first: How the Care Quality Commission work with people who use health and social care services*. September 2013. [Online] [Accessed on 1st November 2016]

http://www.cqc.org.uk/sites/default/files/documents/cqc_putting_people_first_tagged.pdf

Care Quality Commission. (2013b) *Action plan for working with people who use services and the public 2013-2016*. September 2013. [Online] [Accessed on 1st November 2016]

http://www.cqc.org.uk/sites/default/files/documents/20130906_statement_of_involvement_action_plan_final.pdf

Care Quality Commission. (2013c) *Supporting information and guidance: supporting effective clinical supervision*. Publisher details not available. [Online] [Accessed on 2nd June 2017]

https://www.cqc.org.uk/sites/default/files/documents/20130625_800734_v1_00_supporting_information-effective_clinical_supervision_for_publication.pdf

Care Quality Commission. (2016) *The state of health care and adult social care in England 2015/16*. London: HMSO. [Online] [Accessed on 22nd January 2017]

http://www.cqc.org.uk/sites/default/files/20161019_stateofcare1516_web.pdf

Carpenter, J., Webb, C., Bostock, L. and Coomber, C. (2012) *Effective supervision in social work and social care*. October. Social Care Institute for Excellence. [Online] [Accessed on 20th July 2017]

http://southwark.proceduresonline.com/pdfs/scie_effective.pdf

Carr, D. (2000) 'Education, profession and culture: some conceptual questions.' *British Journal of Educational Studies*, 48, pp. 248-268. [Online] [Accessed on 25th August 2017] <http://onlinelibrary.wiley.com/doi/10.1111/1467-8527.00146/pdf>

Carter, M., Thompson, N. and Crampton, P. (2013) 'Workplace bullying in the UK NHS: a questionnaire and interview study on prevalence, impact and barriers to reporting.' *British Medical Journal Open* [Online] [Accessed on 16th May 2017]

<http://bmjopen.bmj.com/content/3/6/e002628>

Caza, B. B. and Cortina, L. M. (2007) 'From insult to injury: explaining the impact of incivility.' *Basic and Applied Social Psychology*, 29, pp. 335-350. [Online] [Accessed on 9th October 2017]

<http://www.tandfonline.com/doi/full/10.1080/01973530701665108?scroll=top&needAccess=true>

Charles, A. (2018) Accountable care explained. [Online] [Accessed on 27th February 2018] <https://www.kingsfund.org.uk/publications/accountable-care-explained>

Charmaz, K. (2006). Constructing grounded theory: A practical guide through qualitative analysis. London: Sage.

Cimiotti, J. P., Aiken L. H., Sloane, D. M. and Wu, E. S. (2012) 'Nurse staffing, burnout, and health care associated infection.' *American Journal of Infection Control*, 40, pp. 486-490. [Online] [Accessed on 22nd May 2017] http://www.truthaboutnursing.org/research/shortage/orig/cimotti_staffing.pdf

Clarke, E. J. (2015) *Law and ethics for midwifery*. London: Routledge.

Clarke, S. P. and Aiken, L. H. (2008) 'An international hospital outcomes research agenda focused on nursing: lessons from a decade of collaboration.' *Journal of Clinical Nursing*, 17(24), pp. 3317-3323. [Online] [Accessed on 3rd October 2017] <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2629356/>

Cohen, M. Z. (1987). A historical overview of the phenomenological movement. *Image: The Journal of Nursing Scholarship*, 19(1), 31-34. [Online] [Accessed on 20th June 2016] <https://sigmapubs.onlinelibrary.wiley.com/doi/pdf/10.1111/j.1547-5069.1987.tb00584.x>

Cohen, D. and Crabtree, B. F. (2006) Qualitative Research Guidelines Project: semi-structured interviews. July. Robert Wood Johnson Foundation. [Online] [Accessed on 1st June 2016] <http://www.qualres.org/HomeSemi-3629.html>

Cohen, M. Z. and Omery, A. (1994) 'Schools of phenomenology: implications for research.' In Morse, J. (ed.) *Critical Issues in Qualitative Research Methods*. London: SAGE Publications, pp. 137–156.

Cohen, M. Z., Kahn, D. L. and Steeves, R. H. (2000) *Hermeneutic phenomenological research: a practical guide for nurse researchers*. Thousand Oaks, Calif.: SAGE Publications.

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In

R.Valle & M. King (Eds.), *Existential phenomenological alternatives in psychology* (pp. 48-71). New York: Oxford University Press.

Corbin, J. M. and Strauss, A. C. (2008) *Basics of qualitative research: techniques and procedures for developing grounded theory*. 3rd ed. Thousand Oaks, Calif.: SAGE Publications.

Council for Healthcare Regulatory Excellence. (2012) *Council for Healthcare Regulatory Excellence annual report and accounts 2011 to 2012*. [Online] [Accessed on 23rd November 2016.]

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/247050/0200_i.pdf

Council of Deans for Health. (2016) *Educating the future nurse – a paper for discussion. Our initial views key outcomes future registered nurse education across all four fields*. Publisher details not available. [Online] [Accessed on 24th July 2017] <https://councilofdeans.org.uk/wp-content/uploads/2016/08/Educating-the-Future-Nurse-FINAL-1.pdf>

[Cox, C. \(2010\) 'Legal responsibility and accountability.' *Nursing management*, 17\(3\), pp. 18-20. \[Online\] \[Accessed on 20th June 2017\]](#)
<http://journals.rcni.com/doi/full/10.7748/nm2010.06.17.3.18.c7797>

Crabtree, B. F. and Miller, W. L. (eds.) (1999) *Doing qualitative research*. Thousand Oaks, California: SAGE Publications.

Creswell, J. W. (1998) *Qualitative inquiry and research design: choosing among five traditions*. Thousand Oaks, Calif.: SAGE Publications.

Creswell, J. W. (2013) *Research design: qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, Calif.: SAGE Publications.

Creswell, J. W. and Plano-Clark, V. L. (2011) *Designing and conducting mixed research methods*. Thousand Oaks, Calif.: SAGE Publications.

Crigger, N. and Godfrey, N. S. (2011) *The making of nurse professionals: a transformational, ethical approach*. Sudbury, MA: Jones & Bartlett Learning.

- Crotty, M. (1996) *Phenomenology and nursing research*. London: Churchill Livingstone.
- Cummings, J. (2013) *Compassion in practice*. NHS England. [Online] [Accessed on 20th July 2017]
http://www.cln.nhs.uk/document_uploads/CongressResources/CompassionInPractice_JC.pdf
- Currie, G., Waring, J. and Finn, R. (2008) 'The limits of knowledge management for UK public services modernization: the case of patient safety and service quality.' *Public Administration*, 86(2), pp. 363-385.
- Curtis, J., Bowen, I. and Reid, A. (2007) 'You have no credibility: nursing students' experiences of horizontal violence.' *Nurse Education in Practice*, 7(3), pp. 156-163. [Online] [Accessed on 13th December 2016]
<http://www.sciencedirect.com.ezproxy.mmu.ac.uk/science/article/pii/S1471595306000710>
- Dahlberg, K., Dahlberg, H. and Nystrom, M. (2008) *Reflective lifeworld research*. 2nd ed., Lund: Student literature.
- Dancer, M. (2017) *The legal implications of the GMC and NMC merging*. 27th February. Management in Practice blog. [Online] [Accessed on 30th May 2017]
<http://www.managementinpractice.com/editors-pick/blog-legal-implications-gmc-and-nmc-merging>
- Darbyshire, P. and McKenna, L. (2013) 'Nursing's crisis of care: what part does nursing education own?' *Nurse Education Today*, 33(4), pp. 305-307.
- Data Protection Act 1998. (c. 29) London: TSO. [Online] [Accessed 1st February 2015]. <http://www.legislation.gov.uk/ukpga/1998/29/contents>
- De Zulueta, P. (2013) 'Reflecting on the Francis Report: how we can develop more human systems of care.' *Nursing Ethics*, 20(7), pp. 838-839.
- Denscombe, M. (2003) *The good research guide: for small-scale social research projects*. 2nd ed., Maidenhead: Open University Press.

Denzin, N. K. (1989) *Interpretive biography*. Thousand Oaks, California: SAGE Publications.

Denzin, N. K. and Lincoln, Y. S. (2003) *Handbook of qualitative research*. Thousand Oaks, California: SAGE Publications.

Department of Health. (1997) *The new NHS: modern, dependable*. Command. Cm. 3807, London: TSO. [Online] [Accessed on 20th April 2017]
http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008869

Department of Health. (1998) *A first class service: quality in the new NHS*. [Online] [Accessed on 20th April 2017]
http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006902

Department of Health (1993) *Vision for the Future: The Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare*. HMSO, London.

Department of Health. (2002) *Learning from Bristol: The Department of Health's response to the report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995*. Command. Cm. 5363, London: TSO. [Online] [Accessed on 20th June 2017]
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/273320/5363.pdf

Department of Health. (2008) *High quality care for all: NHS next stage review final report*. Command. Cm. 7432, London: Department of Health. [Online] [Accessed on 1st November 2016]
<http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Highqualitycareforall/index.htm>

Department of Health. (2009) *The NHS Performance Framework: implementation guidance*. London: Department of Health. [Online] [Accessed on 20th April 2017]
http://webarchive.nationalarchives.gov.uk/20130105144507/http://www.dh.gov.uk/pr od_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098526.pdf

Department of Health. (2013) *Research governance framework for health and social care*. 2nd ed., London: Department of Health. [Online] [Accessed on 4th November 2016]

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/139565/dh_4122427.pdf

Department of Health. (2014) *Corporate report: Department of Health corporate plan 2013 to 2014*. London: Department of Health. [Online] [Accessed on 18th November 2016] <https://www.gov.uk/government/publications/department-of-health-corporate-plan-2013-14/department-of-health-2013-14-corporate-plan>

Department of Health. (2017) *Policy paper: NHS bursary reform*. London: Department of Health. [Online] [Accessed on 25th July 2017] <https://www.gov.uk/government/publications/nhs-bursary-reform/nhs-bursary-reform>

Demarco, S., Roberts, S., Norris, A., and McCurry, M. (2007) 'The development of the Nurse Workplace Scale: self-advocating behaviours and beliefs in the professional workplace.' *Journal of Professional Nursing*, 24(5), pp. 296-301. [Online] [Accessed on 4th October 2017] http://www.sciencedirect.com/science/article/pii/S8755722307002438?_rdoc=1&fmt=high&origin=gateway&docanchor=&md5=b8429449ccfc9c30159a5f9aeaa92ffb

Denis, J-L. (2014) 'Accountability in healthcare organizations and systems.' *Healthcare Policy*, 10(SP), pp. 8-9. [Online] [Accessed on 11th October 2017] <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4255571/>

Dick, B. (2007). What can grounded theorists and action researchers learn from each other? In Bryant, A and Charmaz, K. (Eds.), *The SAGE handbook of grounded theory* (pp. 398–416). London: Sage.

Diekelmann, N. L., Allen, D., and Tanner, C. (1989) *The NLN criteria for appraisal of baccalaureate programs: a critical hermeneutic analysis*. New York: National League for Nursing.

Diekelmann, N. L. (1993) 'Behavioural pedagogy: a Heideggerian hermeneutical analysis of the lived experiences of students and teachers in baccalaureate nursing education.' *Journal of Nursing Education*, 32(6), pp. 245-254.

Dobrowolska, B., Wronska, I., Fidecki, W. and Wysokinski, M. (2007) 'Moral obligations of nurses based on the ICN, UK, Irish and Polish codes of ethics for nurses.' *Nursing Ethics*, 14(2), pp. 171-180. [Online] [Accessed on 25th September 2016] <http://journals.sagepub.com/doi/pdf/10.1177/0969733007073697>

Donley, R. (2005) 'Challenges for nursing in the 21st century.' *Nursing Economics*, 23(6), pp. 312-318. [Online] [Accessed on 11th August 2016] <http://go.galegroup.com.ezproxy.mmu.ac.uk/ps/i.do?p=AONE&u=mmucal5&id=GAL E|A140513175&v=2.1&it=r&sid=summon&userGroup=mmucal5&authCount=1>

Donnelly, H. (2011) 'The Mid Staffordshire NHS Foundation Trust Public Inquiry: Witness statement of Helene Donnelly.' Publication details unknown. [Online] [Accessed on 5th September 2016] <https://minhalexander.files.wordpress.com/2016/09/helen-donnelly-witness-statement-to-mid-staffs-public-inquiry.pdf>

Doyle, S. (2007) 'Member checking with older women: a framework for negotiating meaning.' *Health Care for Women International*, 28(10), pp. 888-908. [Online] [Accessed on 16th November 2016] DOI:10.1080/07399330701615325

Draper, P. (1997) *Nursing perspectives on quality of life*. London: Routledge.

Dreyfus, H. L. (1991) *Being-in-the-world: a commentary on Heidegger's Being and Time, Division I*. Cambridge, MA: MIT Press. [Online] [Accessed on 1st November 2016] https://issuu.com/miranpogacar/docs/dreyfus_-_being-in-the-world_-_a_co_1bc307040578c7

Dreyfus, H.L and Dreyfus, S. (1985). From Socrates to Expert Systems: The Limits of Calculative Rationality. In C. Mitcham and A. Huning (Eds.), *Philosophy and Technology II: Information Technology and Computers in Theory and Practice*. Boston: D. Reidel Publishing Company, pp. 111–130.

- Dreyfus, H. L. and Wrathall, M. A. (eds.) (2008) *A companion to Heidegger*. John Wiley & Sons. [Online] [Accessed on 6th January 2018]
<http://www.counsellingeastlondon.org/wp-content/uploads/2012/07/A-Companion-to-Heidegger.pdf>
- Du Toit, D. (1995) 'A sociological analysis of the extent and influence of professional socialization on the development of a nursing identity among nursing students at two universities in Brisbane, Australia.' *Journal of Advanced Nursing*, 21(1), pp.164-171. DOI: 10.1046/j.1365-2648.1995.21010164.x
- Dubnick, M. J. (2003) 'Accountability and the promise of performance: in search of the mechanisms.' *Public Performance & Management Review*, 28(3), pp. 376-417. [Online] [Accessed on 21st June 2017] <http://www.jstor.org/stable/3381159>
- Dubrosky, R. (2013) 'Iris Young's five faces of oppression applied to nursing.' *Nursing Forum*, 48(3), pp. 205-210. [Online] [Accessed on 4th October 2017]
<http://onlinelibrary.wiley.com/doi/10.1111/nuf.12027/pdf>
- Duddle, M. and Boughton, M. (2007) 'Intra-professional relations in nursing.' *Journal of Advanced Nursing*, 59(1), pp. 29-37. [Online] [Accessed on 28th November 2016]
<https://www.ncbi.nlm.nih.gov/pubmed/17524047>
- Dunton, N., Gajewski, B., Klaus, S. and Pierson, B. (2007) 'The relationship of nursing workforce characteristics to patient outcomes.' *Journal of Issues in Nursing* 12(3). [Online] [Accessed on 21st July 2017] DOI: 10.3912/OJIN.Vol12No03Man03
- Duranti, A. (1997) *Linguistic anthropology*. Cambridge: Cambridge University Press.
- Dyess, S. and Sherman, R. (2009) 'The first year of practice: new graduate nurses' transition and learning needs.' *Journal of Continuing Education in Nursing*, 40(9), pp. 403-410. [Online] [Accessed on 14th September 2016] DOI: 10.3928/00220124-20090824-03
- Eagleton, T. (1996) *Literary theory: an introduction*. 2nd ed., Minneapolis: University of Minnesota Press.

Ecclestone, K. and Hayes, D. (2009) *The dangerous rise of therapeutic education*. Abingdon: Routledge.

Edwards, B. (2002) 'Deep insider research.' *Qualitative Research Journal*, 2(1), pp. 71-84.

Einarsen, S., Hoel, H. and Notelaers, G. (2009) 'Measuring exposure to bullying and harassment at work: validity, factor structure and psychometric properties of the Negative Acts Questionnaire-Revised.' *Work & Stress*, 23(1), pp. 24-44. [Online] [Accessed on 9th October 2017] <https://doi.org/10.1080/02678370902815673>

Enosh, G. and Ben-Ari, A. (2016) 'Reflexivity: the creation of liminal spaces - researchers, participants, and research encounters.' *Qualitative Health Research*, 26(4), pp. 578-584.

Epstein, A. M. (2009) 'Revisiting readmissions: changing the incentives for shared accountability.' *The New England Journal of Medicine*, 360, pp. 1457-1459.

Erenstein, C. and McCaffrey, R. (2007) 'How healthcare work environments influence nurse retention.' *Holistic Nursing Practice*, 21(6), pp. 303-307.

Esterhuizen, P. (2006) 'Is the professional code still the cornerstone of clinical nursing practice?' *Journal of Advanced Nursing*, 53(1), pp. 104-113. [Online] [Accessed on 10th October 2016] <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2648.2006.03684.x/pdf>

Evaneshko, V. and Kay, M. A. (1982) 'The ethnoscience research technique.' *Western Journal of Nursing Research*, 4(1), pp. 49-64. [Online] [Accessed on 15th June 2016] <http://journals.sagepub.com/doi/pdf/10.1177/019394598200400105>

Fagermoen, M. S. (1997) 'Professional identity: values embedded in meaningful nursing practice.' *Journal of Advanced Nursing*, 25(3), pp. 434-441.

Farrell, G. A., Bobrowski, C. and Bobrowski, P. (2006) 'Scoping work place aggression in nursing: findings from an Australian study.' *Journal of Advanced Nursing*, 55(6), pp. 778-787. [Online] [Accessed on 8th December 2016] <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2648.2006.03956.x/pdf>

Finch, J. (2003) 'Commentary: a look at the bigger picture in building research capacity.' *Journal of Research*, 8(6), pp. 427-428. DOI: 10.1177/136140960300800605

Finlay, L. (2012) 'Debating phenomenological methods.' In Friesen, N., Henriksson, C. and Saevi, T. (eds.) *Hermeneutic phenomenology in education*. Rotterdam: Sense Publishers, pp. 17-37.

Firestone, W. A. (1987) 'Meaning in method: the rhetoric of quantitative and qualitative research.' *Educational Researcher*, 16(7), pp. 16-21. [Online] [Accessed on 2nd March 2015] <http://files.eric.ed.gov/fulltext/ED292816.pdf>

Fletcher, K. (2007) 'Image: changing how women nurses think about themselves.' *Journal of Advanced Nursing*, 58(3), pp. 207-215.

Flood, A. (2010) 'Understanding phenomenology: Anne Flood looks at the theory and methods involved in phenomenological research.' *Nurse Researcher*, 17(2), pp. 7-15.

Fontana, A. and Frey, J. (1994) The art of science. In Denzin, N. K. (ed.) *The handbook of qualitative research*. Thousand Oaks, California: SAGE Publications, pp. 361-376. [Online] [Accessed on 23rd October 2016] <http://jan.ucc.nau.edu/~pms/cj355/readings/fontana&frey.pdf>

Foucault, M. (1977) *Discipline and punish: the birth of the prison*. Translated by A. Sheridan, 1991. Harmondsworth: Penguin.

Fowler, M. D. M. (ed.) (2010) *Guide to the Code of ethics for nurses: interpretation and application*. Silver Spring: American Nurses Association. [Online] [Accessed on 23rd June 2017] <http://www.nursesbooks.org/ebooks/download/CodeofEthics.pdf>

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: executive summary*. HC 947. London: TSO. [Online] [Accessed on 20th March 2014]

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Volume 1: Analysis of evidence and lessons learnt (part 1)*. HC 898-I. London: TSO. [Online] [Accessed on 20th March 2014]

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279115/0898_i.pdf

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Volume 2: Analysis of evidence and lessons learnt (part 2)*. HC 898-II. London: TSO. [Online] [Accessed on 20th March 2014]

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279118/0898_ii.pdf

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Volume 3: Present and future Annexes*. HC 898-III. London: TSO. [Online] [Accessed on 20th March 2014]

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279121/0898_iii.pdf

Francis, R. (2015) *Freedom to Speak Up: An Independent Review into Creating an Open and Honest Reporting Culture in the NHS*. [Online] [Accessed on 22nd December 2016] <http://freedomtospeakup.org.uk/the-report/>

Frankel, A. S., Leonard, M. W. and Denham, C. R. (2006) 'Fair and just culture, team behaviour, and leadership engagement: the tools to achieve high reliability.' *Health Research and Educational Trust*. 1690-1709 [Online] [Accessed on 20th June 2017] <https://pdfs.semanticscholar.org/1b4e/b16e2ad0f4255ea3d223bf3f6ccd9a1ad242.pdf>

Freidson, E. (1994) *Professionalism reborn: theory, prophecy and policy*. Chicago: University of Chicago Press.

Freidson, E. (1970) *Professional dominance: the social structure of medical care*. New York: Atherton Press.

Freire, P. (1970) *Pedagogy of the oppressed*. New York: Herder & Herder.

Gadamer, H-G. (1976) *Philosophical hermeneutics*. Translated and edited by D. E. Linge, 2008. 2nd ed., Berkeley: University of California Press.

Gadamer, H-G. (1975) *Truth and method*. Translated by J. Westheimer and D. G. Marshall, 1996. 2nd ed., London: Continuum. [Online] [Accessed on 20th November 2014] <https://mvlindsey.files.wordpress.com/2015/08/truth-and-method-gadamer-2004.pdf>

Garza, G. (2007) 'Varieties of phenomenological research at the University of Dallas: an emerging typology.' *Qualitative Research in Psychology*, 4(4), pp. 313-342. [Online] [Accessed on 8th September 2015] <http://www.tandfonline.com/doi/full/10.1080/14780880701551170?needAccess=true>

Gaskell, G. (2000). Individual and group interviewing. *Qualitative researching with text, image and sound*, 38-56. [Online] [Accessed on 10th October 2018] <http://www.willsull.net/la597/resources/28-March/4-gaskell.pdf>

Gaudine, A., LeFort, S. M., Lamb, M. and Thorne, L. (2011) 'Ethical conflicts with hospitals: the perspective of nurses and physicians.' *Nursing Ethics*, 18(6), pp. 756-766. [Online] [Accessed on 30th October 2017] <http://journals.sagepub.com/doi/full/10.1177/0969733011401121>

Geanellos, R. (1998) 'Hermeneutic philosophy. Part II: a nursing research example of the hermeneutic imperative to address forestructures/pre-understandings.' *Nursing Inquiry*, 5(4), pp. 238-247. [Online] [Accessed on 14th September 2014] DOI: 10.1046/j.1440-1800.1998.00243.x

General Medical Council. (2015) *Building a supportive environment: a review to tackle undermining and bullying in medical education and training*. London: GMC. [Online] [Accessed on 1st January 2017] https://www.gmc-uk.org/Under_embargo_05_03_15_Building_a_supportive_environment.pdf_59988406.pdf

General Medical Council. (2017) *GMC statement: GMC encourages doctors in training to use exception reports*. 9th of March. [Online] [Accessed on 28th July 2017] <http://www.gmc-uk.org/news/29296.asp>

George, V., and Luhrsens, M. (2014). 'Professional governance: to act - not just inform.' *Nurse Leader*, 2(12), pp. 48-54. [Online] [Accessed on 11th October 2017] [http://www.nurseleader.com/article/S1541-4612\(14\)00027-5/pdf](http://www.nurseleader.com/article/S1541-4612(14)00027-5/pdf)

Gerrish, K. and Lacey, A. (2006) *The research process in nursing*. 5th ed., Oxford: Blackwell.

Gifford, B. D., Zammuto, R. F. and Goodman, E. A. (2002) 'The relationship between hospital unit culture and nurses' quality of work life.' *Journal of Healthcare Management*, 47(1), pp. 13-25. [Online] [Accessed on 12th June 2017] <http://www.biomedsearch.com/article/relationship-between-hospital-unit-culture/92035494.html>

Gillespie, B. M., Chaboyer, W. and Wallis, M. (2007) 'Development of a theoretically derived model of resilience through concept analysis.' *Contemporary Nurse*, 25(1-2), pp. 24-135.

Gillespie, B. M., Chaboyer, W. and Wallis, M. (2009) 'The influence of personal characteristics on the resilience of operating room nurses: a predictor study.' *International Journal of Nursing Studies*, 46(7), pp. 968-976. [Online] [Accessed on 19th July 2017] http://www.sciencedirect.com/science/article/pii/S0020748907002040?_rdoc=1&_fmt=high&_origin=gateway&_docanchor=&md5=b8429449ccfc9c30159a5f9aeaa92ffb

Giorgi, A. (1989) 'Some theoretical and practical issues regarding the psychological phenomenological method.' *Saybrook Review*, 7(2), pp. 71-85.

Giorgi, A. (2005) 'The phenomenological movement and research in the Human Sciences.' *Nursing Science Quarterly*, 18(1), pp. 75-82. [Online] [Accessed on 21st September 2015] <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.600.1315&rep=rep1&type=pdf>

Giorgi, A. (2000) 'Concerning the application of phenomenology to caring research.' *Scandinavian Journal of Caring Sciences*, 14, pp. 11-15. [Online] [Accessed on 3rd November 2016]

https://www.researchgate.net/profile/Ashwin_Kumar39/publication/281785675_document/links/55f899d608aeba1d9f0cfa9.pdf

Girvin, J. (2015) 'Editorial: The public understanding of nursing – time for a step change?' *Journal of Clinical Nursing*, 24(23–24), pp. 3341–3342.

Girvin, J., Jackson D. and Hutchinson M. (2016) 'Contemporary public perceptions of nursing: a systematic review and narrative synthesis of the international research evidence.' *Journal of Nursing Management*, 24(8), pp. 994-1006. [Online] [Accessed on 1st November 2017]

<http://onlinelibrary.wiley.com/doi/10.1111/jonm.12413/full>

Glaser, B. G. (1992). *Basics of grounded theory analysis: Emergence vs forcing*. Sociology press.

Glaser, B.G. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, CA: Sociology Press.

Glaser, B. and Strauss, A. (1967) *The discovery of grounded theory: strategies for qualitative research*. New York: Aldine Publishing Company.

Goble, E. (2014) *The experience of encountering the sublime*. Phenomenology Online: A Resource for Phenomenological Inquiry. [Online] [Accessed on 1st June 2016] <http://www.phenomenologyonline.com/sources/textorium/goble-erika-the-experience-of-encountering-the-sublime/>

Goffman, E. (1959) *The presentation of self in everyday life*. New York: Anchor Books.

Goleman, D. (1998) *Working with Emotional Intelligence*. Bloomsbury publishing, London.

Gonge, H. and Buus, N. (2011) 'Model for investigating the benefits of clinical supervision in psychiatric nursing: a survey study.' *International Journal of Mental Health Nursing*, 20(2), pp. 102–11.

González-de Paz, L., Kostov, B., Sisó-Almirall, A. and Zabalegui-Yárnoz, A. (2012) 'A Rasch analysis of nurses' ethical sensitivity to the norms of the code of conduct.' *Journal of Clinical Nursing*, 21(19-20), pp. 2747-2760. [Online] [Accessed on 5th October 2017] <http://onlinelibrary.wiley.com.ezproxy.mmu.ac.uk/doi/10.1111/j.1365-2702.2012.04137.x/pdf>

Greenwood, J. (1993) 'The apparent desensitization of student nurses during their professional socialization: a cognitive perspective.' *Journal of Advanced Nursing*, 18(9), pp. 1471-1479. [Online] [Accessed on 10th October 2017] <http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.1993.18091471.x/pdf>

Grey, B. and Smith, P. (2009) 'Emotional labour and the clinical settings of nursing care: the perspectives of nurses in East London.' *Nurse Education in Practice*, 9(4), pp. 253–261. [Online] [Accessed on 13th March 2017] <http://www.sciencedirect.com/science/article/pii/S147159530800098X>

Griffiths, P., Ball, J., Murrells, T., Jones, S. and Rafferty, A. M. (2016) 'Registered nurse, healthcare support worker, medical staffing levels and mortality in English hospital trusts: a cross-sectional study.' *British Medical Journal Open*, 6:e008751. [Online] [Accessed on 9th January 2017] DOI: 10.1136/bmjopen-2015-008751

Gross, R. E. (2017). Warmth and Competence Traits: Perceptions of Female and Male Nurse Stereotypes [Online] [Accessed on 8th January 2018] https://academicworks.cuny.edu/cgi/viewcontent.cgi?referer=https://scholar.google.co.uk/&httpsredir=1&article=2948&context=gc_etds

Grossman, S. C. and Valiga, T. M. (2017) *The new leadership challenge: creating the future of nursing*. 5th ed., Philadelphia: FA Davis.

Guba, E. G. and Lincoln, Y. S. (1989) *Fourth generation evaluation*. Thousand Oaks, California: SAGE Publications.

Gullion, J. S. (2016) *Writing Ethnography*. Rotterdam: Sense Publishers.

Hahtela, N., Paavilainen, E., McCormack, B., Slater, P., Helminen, M. and Suominen, T. (2015) 'Influence of workplace culture on nursing-sensitive nurse outcomes in municipal primary health care.' *Journal of nursing management*, 23(7), pp. 931-939. [Online] [Accessed on 22nd July 2017] https://www.researchgate.net/profile/Paul_Slater4/publication/262492823_Influence_of_workplace_culture_on_nursing_sensitive_nurse_outcomes_in_municipal_primary_health_care/links/5707c76708aed09e916d1b00.pdf

Haigh, C. and Witham, G. (2015) *Distress Protocol for qualitative data collection*. Manchester: Manchester Metropolitan University. [Online] [Accessed on 3rd April 2015] <https://www2.mmu.ac.uk/media/mmuacuk/content/documents/rke/Advisory-Distress-Protocol.pdf>

Hales, G., May, T., Belur, J. and Hough, M. (2015) *Chief officer misconduct in policing: an exploratory study*. Unknown place of publication: College of Policing. [Online] [Accessed on 10th October 2016] http://www.icpr.org.uk/media/39352/150317_Chief_officer_misconduct_FINAL_%20REPORT.pdf

Hallett, C. (1995) 'Understanding the phenomenological approach to research.' *Nurse Researcher*, 3(2), pp. 55-65. [Online] [Accessed on 25th August 2016] <http://journals.rcni.com/doi/pdfplus/10.7748/nr.3.2.55.s6>

Hansen, H. E. (1995) 'A model for collegiality among staff nurses in acute care.' *Journal of Nursing Administration*, 25(12), pp. 11-20.

Harmon, M. and Mayor, R. (1986) *Organisation theory for public administration*. Boston: Little, Brown.

Hart, C. (2018). *Doing a Literature Review: Releasing the Research Imagination*. Sage.

Health Education England. (2016) *Workforce plan for England 2016: investing in people for health and healthcare*. [Online] [Accessed on 26th September 2017] https://www.hee.nhs.uk/sites/default/files/documents/HEE%20Workforce%20Plan%20for%20England%202016%20180516_0.pdf

Health Education England. (2016) *Nursing Associate Curriculum Framework*. [Online] [Accessed on 16th June 2017] <https://www.hee.nhs.uk/sites/default/files/documents/Curriculum%20Framework%20Nursing%20Associate.pdf>

Heathcote, T. (2013) *There is a culture of "fear and intimidation" in nursing, RCN warns*. 23rd April. HR magazine. [Online] [Accessed on 20th June 2017] <http://www.hrmagazine.co.uk/article-details/there-is-a-culture-of-fear-and-intimidation-in-nursing-rcn-warns>

Hegney, D., Eley, R., Plank, A., Buikstra, E. and Parker, V. (2006) 'Workforce issues in nursing in Queensland: 2001 and 2004.' *Journal of Clinical Nursing*, 15(12), pp. 1521-1530.

Heidegger, M. (1927) *The basic problems of phenomenology*. Translated by A. Hofstadter, 1988. Bloomington: Indiana University Press.

Heidegger, M. (1927) *Being and time*. Translated by J. Stambaugh, 2010. New York: SUNY Press.

Heidegger, M. (1993) *Basic writings: from Being and Time (1927) to The Task of Thinking (1964)*. London: Routledge.

Heidegger, M. (1966) *Discourse of thinking*. Translated by J. Anderson and E. Freund, 1959. New York: Harper Collins.

Heidegger, M. (1976) *What is called thinking?* Translated by J. Glenn-Gray. New York: Harper Collins.

Helman, C. (2007) *Culture, health and illness*. 5th ed., London: Hodder Arnold.

Hess, R. G. and Swihart, D. (2013) 'Shared governance: what it can mean for nurses.' *Nursing Spectrum*, 25(1), pp. 38-43.

Hinchliff, S., Norman, S. and Schober, J. (2008) *Nursing practice and health care*. 5th ed., London: Edward Arnold.

Hippeli, F. (2009) 'Nursing: does it still eat its young or have we progressed beyond this?' *Nursing Forum*, 44(3), pp. 186-188. [Online] [Accessed on 15th June 2017]
DOI: 10.1111/j.1744-6198.2009.00141.x

Hochschild, A. R. (1983) *The managed heart: commercialization of human feeling*. Berkeley: University of California Press.

Hodges, H. F., Troyan, P. J. and Keeley, A. C. (2010) 'Career persistence in baccalaureate-prepared acute care nurses.' *Journal of Nursing Scholarship*, 42(1), pp. 83-91. [Online] [Accessed on 12th October 2017]
<http://onlinelibrary.wiley.com/doi/10.1111/j.1547-5069.2009.01325.x/full>

Hogan, H., Zipfel, R., Neuburger, J., Hutchings, A., Darzi, A., & Black, N. (2015). Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. [Online] [Accessed on 5th June 2017] *bmj*, 351, h3239. <https://www.bmj.com/content/351/bmj.h3239.long>

Holland, C. K. (1993) 'An ethnographic study of nursing culture as an exploration for determining the existence of a system of ritual.' *Journal of Advanced Nursing*, 18(9), pp. 1461-1470. [Online] [Accessed on 15th June 2017] DOI:10.1046/j.1365-2648.1993.18091461.x

Houghton, C. E., Casey, D., Shaw, D., and Murphy, K. (2013). Students' experiences of implementing clinical skills in the real world of practice. *Journal of Clinical Nursing*, 22(13-14), 1961-1969. [Online] [Accessed on 10th July 2017]
http://eprints.teachingandlearning.ie/2547/1/Houghton%20et%20al%202013%20%20JCN_Factors_post_review.pdf

Houghton, C. E. (2014). 'Newcomer adaptation': a lens through which to understand how nursing students fit in with the real world of practice. *Journal of clinical nursing*, 23(15-16), 2367-2375. [Online] [Accessed on 10th July 2017]
<https://onlinelibrary.wiley.com/doi/pdf/10.1111/jocn.12451>

Hsieh, H-F., Chen, Y-M., Wang, H-H., Chang, S-C. and Ma, S-C. (2016) 'Association among components of resilience and workplace violence-related depression among emergency department nurses in Taiwan: a cross-sectional study.' *Journal of Clinical Nursing*, 25(17-18), pp. 2639–2647. [Online] [Accessed on 21st July 2017]

<http://onlinelibrary.wiley.com/doi/10.1111/jocn.13309/full>

Hudec, P. (2006) 'Collegiality: a 21st century answer.' *KMWorld*, 15(6), pp. 18-30.

Hudgins, T. A. (2016) 'Resilience, job satisfaction and anticipated turnover in nurse leaders.' *Journal of Nursing Management*, 24(1), E62–E69. [Online] [Accessed on 13th October 2017] <http://onlinelibrary.wiley.com/doi/10.1111/jonm.12289/full>

Hughes, R. L., Ginnett, R. C. and Curphy, G. J. (2006) *Leadership: enhancing the lessons of experience*. 5th ed., Boston: McGraw Hill.

Hunt, J. (2016) From a blame culture to a learning culture. Speech to WHO Global Patient Safety Summit, 10.03.16. [Online] [Accessed on 5th July 2017]

<https://www.gov.uk/government/speeches/from-a-blame-culture-to-a-learning-culture>

Hunt, J. (2015) Making healthcare more human-centred and not system-centred. 15th July. Gov.UK. [Online] [Accessed on 5th July 2017]

<https://www.gov.uk/government/speeches/making-healthcare-more-human-centred-and-not-system-centred>

Huntington, A., Gilmour, J., Tuckett, A., Neville, S., Wilson, D. and Turner, C. (2011) 'Is anybody listening? A qualitative study of nurses' reflections on practice.' *Journal of Clinical Nursing*, 20(9-10), pp. 1413-1422. [Online] [Accessed on 12th March 2017]

<http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2702.2010.03602.x/abstract;jsessionid=301317F0113DE75AB0C8B6CBD3A6D0DB.f04t01>

Husserl, E. (1901) *Logical investigations*. Translated by J. N. Findlay, 1970. New York: Humanities Press.

Husserl, E. (1912) *Ideas pertaining to a pure phenomenology and to a phenomenological philosophy*. Translated by R. Rojcewicz and A. Schuwer, 1989. Dordrecht and Boston: Kluwer Academic Publishers.

Husserl, E. (1936) *The crisis of European sciences and transcendental phenomenology: an introduction to phenomenological philosophy*. Translated by D. Carr, 1970. Evanston: North-western University Press.

Hussey, T. (1996) 'Nursing ethics and codes of professional conduct.' *Nursing Ethics*, 3(3), pp. 250-258. [Online] [Accessed on 1st June 2017]
<http://nej.sagepub.com/content/3/3/250.full.pdf+html?hwshib2=authn%3A1424180172%3A20150216%253A261ce7dc-487d-4449-916c-e331ef530efb%3A0%3A0%3A0%3AFIEp%2F4i3QedikZTiaRBTyQ%3D%3D>

Hutchinson, M., Vickers, M., Jackson, D. and Wilkes, L. (2006) 'Workplace bullying in nursing: towards a more critical organisational perspective.' *Nursing Inquiry*, 13(2), pp. 118-126. [Online] [Accessed on 13th December 2016] DOI: 10.1111/j.1440-1800.2006.00314.x

Hutchinson, M., Vickers, M. H., Wilkes, L. and Jackson, D. (2010) 'A typology of bullying behaviours: the experiences of Australian nurses.' *Journal of Clinical Nursing*, 19(15-16), pp. 2319-2328. [Online] [Accessed on 9th October 2017] DOI: 10.1111/j.1365-2702.2009.03160.x

International Council of Nurses. (2012) *The ICN code of ethics for nurses*. Geneva: ICN. [Online] [Accessed on 4th May 2015]
http://www.icn.ch/images/stories/documents/about/icncode_english.pdf

Ion, R., Smith, K., Nimmo, S., Rice, A. M. and McMillan, L. (2015) 'Factors influencing student nurse decisions to report poor practice witnessed while on placement.' *Nurse Education Today*, 35(7), pp. 900-905. [Online] [Accessed on 22nd December 2016]
<http://www.sciencedirect.com/science/article/pii/S0260691715000775>

Jack, K. F. (2011) *Emotional nurse being: a Heideggerian hermeneutical analysis*. Doctoral dissertation. Manchester Metropolitan University. [Online] [Accessed on 25th May 2016]
https://my.rcn.org.uk/_data/assets/pdf_file/0012/496578/Jack_KF_complete_thesis.pdf

Jack, K. and Wibberley, C. (2014) 'The meaning of emotion work to student nurses: a Heideggerian analysis.' *International Journal of Nursing Studies*, 51(6), pp. 900-907. [Online] [Accessed on 7th December 2017]

<http://www.sciencedirect.com/science/article/pii/S0020748913003015>

Jackson, D., Firtko, A. and Edenborough, M. (2007) 'Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: a literature review.' *Journal of Advanced Nursing*, 60(1), pp. 1-9. [Online] [Accessed on 20th July 2017] DOI:10.1111/j.1365-2648.2007.04412.x

Jackson, D., Peters, K., Andrew, S., Edenborough, M., Halcomb, E., Luck, L., Salamonson, Y. and Wilkes, L. (2010) 'Understanding whistleblowing: qualitative insights from nurse whistle-blowers.' *Journal of Advanced Nursing*, 66(10), pp. 2194-2201. [Online] [Accessed on 21st December 2016] DOI: 10.1111/j.1365-2648.2010.05365.x

Jackson, D., Hutchinson, M., Peters, K., Luck, L. and Saltman, D. (2013) 'Understanding avoidant leadership in health care: findings from a secondary analysis of two qualitative studies.' *Journal of Nursing Management*, 21(3), pp. 572-580. [Online] [Accessed on 11th October 2017]

http://epubs.scu.edu.au/cgi/viewcontent.cgi?article=2386&context=hahs_pubs

James, A. (2017) *Dawn of the super regulator*. 22nd March. Independent Nurse. [Online] [Accessed on 3rd July 2017] <http://www.independentnurse.co.uk/news/dawn-of-the-super-regulator/153045/>

Jameton, A. (1993) 'Dilemmas of moral distress: moral responsibility and nursing practice.' *AWHONNS Clinical Issues Pertaining to Women's Health Nursing*, 4(4), pp. 542-551.

John, W. S. and Johnson, P. (2000) 'The pros and cons of data analysis software for qualitative research.' *Journal of Nursing Scholarship*, 32(4), pp. 393-397. doi:10.1111/j.1547-5069.2000.00393.x

Johns, C. (2003) *Guided reflection: advancing practice*. Oxford: Blackwell Science.

Johnstone, M.J. and Kanitsaki, O. (2006) 'The ethics and practical importance of defining, distinguishing and disclosing nursing errors: a discussion paper.' *International Journal of Nursing Studies*, 43, pp. 367-376. [Online] [Accessed on 5th October 2017] <http://learn.niu.edu/uhrs410/docs/Nursing/Johnstone.pdf>

Jones, A. (2016) 'The role of employee whistleblowing and raising concerns in an organizational learning culture – elusive and laudable? Comment on "Cultures of Silence and Cultures of Voice: The Role of Whistleblowing in Healthcare Organisations."' *International Journal of Health Policy and Management*, 5(1), pp. 67-69. [Online] [Accessed on 11th October 2017] <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4676976/>

Kafle, N. P. (2011) 'Hermeneutic phenomenological research method simplified.' *Bodhi: An Interdisciplinary Journal*, 5(1), pp. 181-200. [Online] [Accessed on 29th September 2016] http://www.ku.edu.np/bodhi/vol5_no1/11.%20Narayan%20Kafle.%20Hermeneutic%20Phenomenological%20Research%20Method.pdf

Kalisch, B. J., Landstrom, G. and Hinshaw, A. S. (2009) 'Missed nursing care: a concept analysis.' *Journal of Advanced Nursing*, 65(7), pp. 1509-1517.

Kalisch, B. J. and Kalisch, P. A. (1983) 'Improving the image of nursing.' *American Journal of Nursing*, 83(1), pp. 48-52.

Kalisch, B. J., Curley, M. and Stefanov, S. (2007) 'An intervention to enhance nursing staff teamwork and engagement.' *Journal of Nursing Administration*, 37(2), pp. 77-84. [Online] [Accessed on 6th December 2016] http://www.nursingcenter.com/journalarticle?Article_ID=693686

Kangas, S., Kee, C. C. and McKee-Waddle, R. (1999) 'Organizational factors, nurses' job satisfaction, and patient satisfaction with nursing care.' *Journal of Nursing Administration*, 29(1), pp. 32-42. [Online] [Accessed on 24th February 2017] http://journals.lww.com/jonajournal/Abstract/1999/01000/Organizational_Factors,_Nurses_Job_Satisfaction,.6.aspx

- Karimi, L., Leggat, S. G., Donohue, L., Farrell, G. and Couper, G. E. (2013) 'Emotional rescue: the role of emotional intelligence and emotional labour on well-being and job-stress among community nurses.' *Journal of Advanced Nursing*, 70(1), pp. 176-186. [Online] [Accessed on 12th October 2017] <http://onlinelibrary.wiley.com/doi/10.1111/jan.12185/full>
- Keogh, B. (2013a) *NHS Services, seven days a week*. Publication details not available. [Online] [Accessed on 24th November 2014] <http://www.england.nhs.uk/wp-content/uploads/2013/12/brd-dec-13.pdf>
- Keogh, B. (2013b) *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*. Publication details not available. [Online] [Accessed on 25th November 2014] <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf>
- Kelly, J., Fealy, G. M. and Watson, R. (2012) 'The image of you: constructing nursing identities in YouTube.' *Journal of Advanced Nursing*, 68(8), pp. 1804-1813.
- Kelsey, C. and Hayes, S. (2015) 'Frameworks and models – scaffolding or strait jackets? Problematising reflective practice.' *Nurse Education in Practice*, 15(6), pp. 393-396. [Online] [Accessed on 27th November 2017] <https://www.sciencedirect.com/science/article/pii/S1471595315000876>
- Khadjehturian, R. E. (2012) 'Stopping the culture of workplace incivility in nursing.' *Clinical Journal of Oncology Nursing*, 16(6), pp. 638-639. [Online] [Accessed on 9th October 2017] <https://cjon.ons.org/cjon/16/6/stopping-culture-workplace-incivility-nursing>
- Khatri, N., Brown, G. D. and Hicks, L. L. (2009) 'From a blame culture to a just culture in health care.' *Health Care Management Review*, 34, pp. 312-322.
- Kirkup, B. (2015) *The Report of the Morecambe Bay Investigation*. London: TSO. [Online] [Accessed on 3rd January 2017] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

Kline, R. (2013) *Bullying: the silent epidemic in the NHS*. 15th May. Public World.
[Online] [Accessed on 22nd July 2017]

http://www.publicworld.org/blog/bullying_the_silent_epidemic_in_the_nhs

Koch, T. (2006) 'Establishing rigour in qualitative research: the decision trail.' *Journal of Advanced Nursing*, 53(1), pp. 91-100 [Online] [Accessed on 27th June 2015]

<http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2648.2006.03681.x/full>

Koch, T. (1995) 'Interpretive approaches in nursing research: the influence of Husserl and Heidegger.' *Journal of Advanced Nursing*, 21(5), pp. 827-836. [Online]

[Accessed on 2nd May 2016] <http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.1995.21050827.x/pdf>

Koch, T. (1996) 'Implementation of a hermeneutic inquiry in nursing: philosophy, rigour and representation.' *Journal of Advanced Nursing*, 24(1), pp. 174-184. [Online]

[Accessed on 23rd March 2015] <http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.1996.17224.x/pdf>

Koch, T. and Harrington, A. (1998) 'Reconceptualising rigour: the case for reflexivity.' *Journal of Advanced Nursing*, 28(4), pp. 882-890. [Online] [Accessed on 7th

December 2017] <http://onlinelibrary.wiley.com/wol1/doi/10.1046/j.1365-2648.1998.00725.x/full>

Kohlbacher, F (2006) The Use of Qualitative Content Analysis in Case Study Research. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*,

7 (1). pp. 1-30. [Online] [Accessed on 14th March 2018] <http://www.qualitative-research.net/index.php/fqs/article/view/75/153>

Korthagen, F. A. (2007) 'The gap between research and practice revisited.'

Educational Research and Evaluation, 13(3), pp. 303-310. [Online] [Accessed on 25th May 2017] <http://dx.doi.org/10.1080/13803610701640235>

Kotter, J. P. (1990) *A force for change: how leadership differs from management*. New York: Free Press.

Krautscheid, L. C. (2014) 'Defining professional nursing accountability: a literature review.' *Journal of Professional Nursing*, 30(1), pp. 43-7.

DOI: 10.1016/j.profnurs.2013.06.008

Kutney-Lee, A., Germack, H., Hatfield, L., Kelly, S., Maguire, P., Dierkes, A., Del Guidice, M. and Aiken, L. H. (2016) 'Nurse engagement in shared governance and patient and nurse outcomes.' *Journal of Nursing Administration*, 46(11), pp. 605-612. [Online] [Accessed on 11th October 2017]

http://www.banyanmed.com/images/pdf/Nurse_Engagement_in_Shared_Governance_and_Patient.12.pdf

Kuzel, A. J. (1992). Sampling in qualitative inquiry. In B. F. Crabtree and W. L. Miller (Eds.), *Research methods for primary care, Vol. 3. Doing qualitative research* (pp. 31-44). Thousand Oaks, CA, US: Sage Publications, Inc.

Kvale, S. (1996) *Interviews: an introduction to qualitative research interviewing*. Thousand Oaks, California SAGE Publications.

Kvale, S. and Brinkmann, S. (2009) *Interviews: learning the craft of qualitative research interviewing*. 2nd ed., Thousand Oaks California: SAGE Publications.

Lachman, V. D. (2008) 'Whistleblowing: role of organizational culture in prevention and management.' *MEDSURG Nursing*, 17(4), pp. 265-267.

Lake, E. T. (2007) 'The nursing practice environment: measurement and evidence.' *Medical Care Research Review*, 64(2), pp. 104S-122S.

DOI: 10.1177/1077558707299253

Laming, H. (2009) *The protection of children in England: a progress report*. London: TSO.

Langdridge, D. (2007) *Phenomenological psychology: theory, research and method*. Harlow: Pearson Prentice Hall.

Laschinger, H. K. S., Finegan, J. and Wilk, P. (2009) 'New graduate burnout: the impact of professional practice environment, workplace civility, and empowerment.' *Nursing Economics*, 27(6), pp. 377-383. [Online] [Accessed on 7th October 2017] https://www.researchgate.net/profile/Heather_Laschinger/publication/40849347_New_Graduate_Burnout_The_Impact_Of_Professional_Practice_Environment_Workplace_Civility_And_Empowerment/links/0912f50aae6a19867e000000.pdf

Laschinger, H. K. S., Wong, C. A., and Grau, A. L. (2013). Authentic leadership, empowerment and burnout: a comparison in new graduates and experienced nurses. *Journal of nursing management*, 21(3), 541-552. DOI: 10.1111/j.1365-2834.2012.01375.x.

Lathlean, J. and Le May, A. (2002) 'Communities of practice: an opportunity for interagency working.' *Journal of Clinical Nursing*, 11(3), pp. 394-398. [Online] [Accessed on 19th July 2017] https://www.researchgate.net/profile/Judith_Lathlean/publication/227704785_Communities_of_practice_an_opportunity_for_interagency_working/links/56d04b5508ae4d8d64a372fd.pdf

Lave, J. and Wenger, E. (1991) *Situated learning: legitimate peripheral participation*. Cambridge: University of Cambridge Press.

Laverty, S. M. (2003) 'Hermeneutic phenomenology and phenomenology: a comparison of historical and methodological considerations.' *International Journal of Qualitative Methods*, 2(3), Article 3. [Online] [Accessed on 25th August 2016] http://www.ualberta.ca/~iiqm/backissues/2_3final/pdf/laverty.pdf

Lawler, J. (1998). Phenomenologies as research methodologies for nursing: from philosophy to researching practice. *Nursing Inquiry*, 5(2), 104-111. <https://doi.org/10.1046/j.1440-1800.1998.520104.x>

Lawler, S. (2002). *Mothering the self: Mothers, daughters, subjects*. Routledge.

Le May, A. (2009) *Introducing communities of practice: communities of practice in health and social care*. Oxford: Wiley-Blackwell, pp. 3-16.

Leonard, M. and Frankel, A. (2010) 'The path to safe and reliable healthcare.' *Patient Education and Counselling*, 80(3), pp. 288-292. [Online] [Accessed on 12th November 2016]

https://www.researchgate.net/profile/Michael_Leonard4/publication/45507854_The_path_to_safe_and_reliable_healthcare/links/5417a9da0cf203f155ad5de3.pdf

Leonard, M. and Frankel, A. (2012) *How can leaders influence a safety culture?*

London: The Health Foundation. [Online] [Accessed on 18th January 2017]

<http://www.health.org.uk/sites/health/files/HowCanLeadersInfluenceASafetyCulture.pdf>

Leonard, V. W. (1994) 'Hermeneutics as a method appropriate the Heideggerian phenomenological study of human beings.' In Benner, E. (ed.), *Interpretive phenomenology: embodiment, caring, and ethics in health and illness*. Thousand Oaks: SAGE Publications, pp. 55-63.

Lesser, E. L. and Storck, J. (2001) 'Communities of practice and organizational performance.' *IBM Systems Journal*, 40(4), pp. 831-841. [Online] [Accessed on 19th July 2017]

[http://gcc.upb.de/www/wi/wi2/wi2_lit.nsf/35ae96bebc983d53c12573e70058bbb2/e1c173bb2db8a452c1256b670045efa2/\\$FILE/COP%20and%20Org%20Performance.pdf](http://gcc.upb.de/www/wi/wi2/wi2_lit.nsf/35ae96bebc983d53c12573e70058bbb2/e1c173bb2db8a452c1256b670045efa2/$FILE/COP%20and%20Org%20Performance.pdf)

LeVasseur, J. J. (2003) 'The problem of bracketing in Phenomenology.' *Qualitative Health Research*, 13(3), pp. 408-420. [Online] [Accessed on 23rd November 2014]

<http://journals.sagepub.com/doi/pdf/10.1177/1049732302250337>

Li, L. C., Grimshaw, J. M., Nielsen, C., Judd, M., Coyte, P. C. and Graham, I. D. (2009) 'Evolution of Wenger's concept of community of practice.' *Implementation Science*, 4(1). [Online] [Accessed on 25th May 2017]

<https://implementationscience.biomedcentral.com/articles/10.1186/1748-5908-4-11>

Li, Y., Cao, F., Cao, D. and Liu, J. (2015) 'Nursing students' post-traumatic growth, emotional intelligence and psychological resilience.' *Journal of Psychiatric and Mental Health Nursing*, 22(5), pp. 326-332. [Online] [Accessed on 9th October 2017]

<http://onlinelibrary.wiley.com/doi/10.1111/jpm.12192/full>

Liaschenko, J. and Peter, E. (2004) 'Nursing ethics and conceptualizations of nursing: profession, practice and work.' *Journal of Advanced Nursing*, 46(5), pp. 488-495. [Online] [Accessed on 5th April 2017]

<http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2648.2004.03011.x/full>

Lillibridge, J., Cox, M. and Cross, W. (2002) 'Uncovering the secret: giving voice to the experiences of nurses who misuse substances.' *Journal of Advanced Nursing*, 39(3), pp. 219-229. [Online] [Accessed on 6th June 2017]

<http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.2002.02268.x/full>

Lincoln, Y. S. and Guba, E. G. (1985) *Naturalistic inquiry*. Thousand Oaks, California: SAGE Publications.

Lipscomb, M. and Snelling, P. C. (2010). Student nurse absenteeism in higher education: An argument against enforced attendance. *Nurse education today*, 30(6), 573-578. [Online] [Accessed on 6th September 2017]

<https://www.sciencedirect.com/science/article/pii/S0260691709002330>

LoBiondo-Wood, G. and Haber, J. (2002) *Nursing research methods: critical appraisal and utilisation*. 5th ed. Toronto: Elsevier.

Lok, P. and Crawford, J. (1999) 'The relationship between commitment and organizational culture, subculture, leadership style and job satisfaction in organizational change and development.' *Leadership & Organization Development Journal*, 20(7), pp. 365-373. [Online] [Accessed on 14th March 2017]

<http://dx.doi.org/10.1108/01437739910302524>

Lok, P. and Crawford, J. (2001) 'Antecedents of organizational commitment and the mediating role of job satisfaction.' *Journal of Managerial Psychology*, 16(8), pp. 594-613. [Online] [Accessed on 16th March 2017]

<https://doi.org/10.1108/EUM0000000006302>

Lopez, K. and Willis, D. (2004) 'Descriptive versus interpretive phenomenology: their contributions to nursing knowledge.' *Qualitative Health Research*, 14(5), pp. 726-735. [Online] [Accessed on 1st February 2015]

<http://qhr.sagepub.com/content/14/5/726>

Lopez, R. (2014) 'The relationship between leadership and management: instructional approaches and its connections to organizational growth.' *Journal of Business Studies Quarterly*, 6(1), pp. 98-112. [Online] [Accessed on 3rd January 2017] http://jbsq.org/wp-content/uploads/2014/09/September_2014_7.pdf

Lutgen-Sandvik, P., Tracy, S. J. and Alberts, J. K. (2007) 'Burned by bullying in the American workplace: prevalence, perception, degree and impact.' *Journal of Management Studies*, 44(6), pp. 837-862. DOI: 10.1111/j.1467-6486.2007.00715.x

Lysemose, K. (2013) 'Responsive self-preservation: towards an anthropological concept of responsiveness.' *Meta: Research in Hermeneutics, Phenomenology, and Practical Philosophy*, 5(2) pp. 375-396. [Online] [Accessed on 18th November 2016] http://www.metajournal.org/articles_pdf/375-396-lysemose-meta10-tehno.pdf

Maben, J., Latter, S. and Macleod Clark, J. (2007) 'The sustainability of ideals, values and the nursing mandate: evidence from a longitudinal qualitative study.' *Nursing Inquiry*, 14(2), pp. 99-113. [Online] [Accessed on 4th October 2017] <http://onlinelibrary.wiley.com/doi/10.1111/j.1440-1800.2007.00357.x/full>

Mackintosh, C. (2007) 'Protecting the self: a descriptive qualitative exploration of how registered nurses cope with working in surgical areas.' *International Journal of Nursing Studies*, 44(6), pp. 982-990. [Online] [Accessed on 17th February 2017] <http://www.sciencedirect.com/science/article/pii/S0020748906001258>

McNamara, S, A. (2012) 'Incivility in nursing: unsafe nurse, unsafe patients.' *AORN Journal*, 95(4), pp. 535-540. [Online] [Accessed on 7th October 2017] DOI: 10.1016/j.aorn.2012.01.020

MacPhee, M., Chang, L., Lee, D. and Spiri, W. (2013) 'Global health care leadership development: trends to consider.' *Journal of Healthcare Leadership*, 5, pp. 21-29. [Online] [Accessed on 10th January 2017] DOI <https://doi.org/10.2147/JHL.S23010>

Mackintosh, C. (2006) 'Caring: the socialisation of pre-registration student nurses: a longitudinal qualitative descriptive study.' *International Journal of Nursing Studies*, 43(8), pp. 953-962. [Online] [Accessed on 10th October 2017] https://ac.els-cdn.com/S0020748905002117/1-s2.0-S0020748905002117-main.pdf?_tid=87906e0c-af2f-11e7-babe-00000aab0f02&acdnat=1507800613_0cbc1d04d6dfb5da591e622cd09523c0

Maggs-Rapport, F. (2000) 'Combining methodological approaches in research: ethnography and interpretive phenomenology.' *Journal of Advanced Nursing*, 31(1), pp. 219-225. [Online] [Accessed on 1st June 2015] <http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.2000.01243.x/pdf>

Mahon, M. M. and Nicotera, A. M. (2011) 'Nursing and conflict communication: avoidance as preferred strategy.' *Nursing Administration Quarterly*, 35(2), pp.152-163. [Online] [Accessed on 28th November 2016] <https://www.ncbi.nlm.nih.gov/pubmed/21403489>

Mallak, L. A. (1998) 'Measuring resilience in health care provider organizations.' *Health Manpower Management*, 24(4), pp. 148-152. [Online] [Accessed on 24th May 2017] <http://www.wmich.edu/emrl/Resilience.pdf>

Mannion, R., Freeman, T., Millar, R. and Davies, H. (2016) 'Effective board governance of safe care: a (theoretically underpinned) cross-sectioned examination of the breadth and depth of relationships through national quantitative surveys and in-depth qualitative case studies.' *Health Services and Delivery Research*, 4(4), pp. 1-200. [Online] [Accessed on 27th July 2017] <http://eprints.mdx.ac.uk/18794/1/FullReport-hsdr04040.pdf>

Mansbridge, J. (2014) 'A contingency theory of accountability.' In Bovens, M., Goodin, R. E., and Schillemans, T. (eds.) [*The Oxford handbook of public accountability*](#) (pp.55-68) Oxford: Oxford University Press.
DOI:10.1093/oxfordhb/9780199641253.001.0001

Martin, J. (1992). *Cultures in organizations: Three perspectives*. Oxford University Press.

Martin, J. S., McCormack, B., Fitzsimons, D. and Spirig, R. (2012) 'Evaluation of a clinical leadership programme for nurse leaders.' *Journal of Nursing Management*, 20(1), pp. 72-80. [Online] [Accessed on 23rd October 2017]

<http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2834.2011.01271.x/full>

Marx, D. (2007) 'Patient Safety Patient and the Just Culture'. The just culture community. Outcome Engineering, LLC, pp 1-27 [Online] [Accessed on 20th June 2017] <https://www.unmc.edu/patient-safety/documents/patient-safety-and-the-just-culture.pdf>

Mathes, S. (2011) 'Implementing a caring model.' *Creative Nursing*, 17(1), pp. 36-42.

Matheson, L. K. and Bobay, K. (2008) 'Validation of oppressed group behaviours of nursing.' *Journal of Professional Nursing*, 23(4), pp. 226-234. [Online] [Accessed on 4th October 2017]

http://www.sciencedirect.com/science/article/pii/S8755722307000245?_rdoc=1&_fmt=high&_origin=gateway&_docanchor=&md5=b8429449ccfc9c30159a5f9aeaa92ffb

Maxwell, E. (2016) 'Perspectives: professional regulation: public protection or professional burden?' *Journal of Research in Nursing*, 21(8), pp. 651-655. [Online] [Accessed on 30th June 2017]

<http://journals.sagepub.com/doi/full/10.1177/1744987116678961>

Mayer, J. D. and Salovey, P. (1993) 'The intelligence of emotional intelligence.' *Intelligence*, 17(4), pp. 433-442.

Mayer, J. D., Roberts, R. D. and Barsade, S. G. (2008) 'Human abilities: emotional intelligence.' *Annual Review of Psychology*, 59, pp. 507-536. [Online] [Accessed on 12th October 2017] <https://doi.org/10.1146/annurev.psych.59.103006.093646>

Mays, N. and Pope, C. (1995) 'Rigour and qualitative research.' *British Medical Journal*, 311, pp. 109-12. [Online] [Accessed on 28th November 2015]

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2550154/pdf/bmj00600-0043.pdf>

Mazars. (2016) 'Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015.' [Online] [Accessed on 18th January 2017]

<https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf>

McAllister, M. and Lowe, J. B. (2011) 'Preparing for practice: becoming resilient.' In McAllister, M. and Lowe, J. B. (eds.), *The resilient nurse: empowering your practice*. New York: Springer, pp. 1-22. [Online] [Accessed on 24th July 2016]

http://lghhttp.48653.nexcesscdn.net/80223CF/springer-static/media/samplechapters/9780826105936/9780826105936_chapter.pdf

McAllister, M. and McKinnon, J. (2009) 'The importance of teaching and learning resilience in the health disciplines: a critical review of the literature.' *Nurse Education Today*, 29(4), pp. 371-379. [Online] [Accessed on 12th October 2017]

DOI:10.1016/j.nedt.2008.10.011

McConnell-Henry, T., Chapman, Y. and Francis, K. (2009) 'Unpacking Heideggerian phenomenology.' *Southern Online Journal of Nursing Research*, 9(1), pp. 1-11.

[Online] [Accessed on 22nd September 2014]

http://www.resourcenter.net/images/snrs/files/sojnr_articles2/Vol09Num01Art03.pdf

McDonald, G., Jackson, D., Wilkes, L. and Vickers, M. H. (2013) 'Personal resilience in nurses and midwives: effects of a work-based educational intervention.'

Contemporary Nurse, 45(1), pp. 134-143. [Online] [Accessed on 12th October 2017]

https://www.researchgate.net/profile/Lesley_Wilkes/publication/236937098_Personal_Resilience_in_Nurses_and_Midwives_Effects_of_a_work-based_educational_intervention/links/548514930cf283750c370c9b.pdf

McDonald, G., Jackson, D., Vickers, M. H. and Wilkes, L. (2016) 'Surviving workplace adversity: a qualitative study of nurses and midwives and their strategies to increase personal resilience.' *Journal of Nursing Management*, 24, pp. 123-131.

[Online] [Accessed on 9th October 2017]

<http://onlinelibrary.wiley.com/doi/10.1111/jonm.12293/full>

McDonald, G., Jackson, D., Vickers M. H. and Wilkes, L. (2015) 'Surviving workplace adversity: a qualitative study of nurses and midwives and their strategies to increase personal resilience.' *Journal of Nursing Management*, 24(1). [Online] [Accessed on 30th June 2017]

https://www.researchgate.net/profile/Lesley_Wilkes/publication/274901564_Surviving_workplace_adversity_A_qualitative_study_of_nurses_and_midwives_and_their_strategies_to_increase_personal_resilience/links/5535de310cf20ea35f10eb60/Surviving-workplace-adversity-A-qualitative-study-of-nurses-and-midwives-and-their-strategies-to-increase-personal-resilience.pdf

McLeod, S. (2016) *What is conformity?* Simply Psychology. [Online] [Accessed on 9th January 2017] <https://www.simplypsychology.org/conformity.html>

McQueen, A. C. (2004) 'Emotional intelligence in nursing work.' *Journal of Advanced Nursing*, 47(1), pp. 101-108. [Online] [Accessed on 15th November 2016]
DOI:10.1111/j.1365-2648.2004.03069.x

Meagher, K. M. (2011) 'Considering virtue: public health and clinical ethics.' *Journal of Evaluation in Clinical Practice*, 17(5), pp. 888-893. [Online] [Accessed on 24th October 2016] DOI: 10.1111/j.1365-2753.2011.01721.x

Meleis, A. I. (1996) 'Culturally competent scholarship: substance and rigor.' *Advances in Nursing Science*, 19(2), pp.1-16.

Menkes, J. (2011) *Better under pressure: how great leaders bring out the best in themselves and others*. Boston: Harvard Business School Publishing.

Merleau-Ponty, M. (1945) *Phenomenology of perception*. Translated by C. Smith, 2005. London: Routledge. [Online] [Accessed on 20th July 2017] <http://alfa-omnia.com/resources/Phenomenology+of+Perception.pdf>

Merleau-Ponty, M. (1964) *The primacy of perception*. Translated by W. Cobb. Evanston: Northwestern University Press.

Merrifield, N. (2016) Nursing regulator should be more 'closely aligned' with system checkers like CQC. Nursing Times. [Online] [Accessed on 3rd May 2017]
<https://www.nursingtimes.net/news/professional-regulation/call-for-nmc-to-take-into-account-employer-pressures/7011341.article?search=https%3a%2f%2fwww.nursingtimes.net%2fsearch>

Merton R. K. (1968) *Social theory and social structure*. New York: Free Press.

Meulenbergs, T., Verpeet, E., Schotsmans, P. and Gastmans, C. (2004) 'Professional codes in a changing nursing context: literature review.' *Journal of Advanced Nursing*, 46(3), pp. 331-336. [Online] [Accessed on 28th April 2017]
<http://www.ncbi.nlm.nih.gov/pubmed/15066114>

Middleton, J. (2009) *Whistleblowing nurse Margaret Haywood reinstated*. 13th October. Nursing Times. [Online] [Accessed on 28th July 2017]
<https://www.nursingtimes.net/news/whistleblowing/whistleblowing-nurse-margaret-haywood-reinstated/5007290.article>

Mikaelian, B., & Stanley, D. (2016). Incivility in nursing: from roots to repair. *Journal of nursing management*, 24(7), 962-969.[Online] [Accessed on 22nd July 2017]
<https://onlinelibrary.wiley.com/doi/full/10.1111/jonm.12403>

Milton, C. L. (2008) 'Accountability in nursing: reflecting on ethical codes and professional standards of nursing practice from a global perspective.' *Nursing Science Quarterly*, 21(4), pp. 300-303. DOI:10.1177/0894318408324314

Ministry of Defence. (2013) *The MOD bullying and harassment complaints procedures: a guide for all MOD service and civilian personnel about making, responding to, advising on, investigating, and deciding on, complaints of bullying and harassment*. London: MOD. [Online] [Accessed on 1st January 2017]
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209888/JSP763_1_July_2013.pdf

Moayed, F. A., Daraiseh, N., Shell, R. and Salem, S. (2006) 'Workplace bullying: a systematic review of risk factors and outcomes.' *Theoretical Issues in Ergonomics Science*, 7(3), pp. 311-327.

Moran, D. (2005) *Edmund Husserl: founder of phenomenology*. Malden: Polity Press.

Morley, D. A. (2015) *A grounded theory study exploring first year student nurses' learning in practice*. Doctor of Professional Practice. Bournemouth University. [Online] [Accessed on 25th May 2017]
http://eprints.bournemouth.ac.uk/25017/1/MORLEY%2C%20Dawn%20Angels_D.Pr of. 2015.pdf

Morris-Thompson, T., Shepherd, J., Plata, R. and Marks-Maran, D. I. (2011) 'Diversity, fulfilment and privilege: the image of nursing.' *Journal of Nursing Management*, 19(5), pp. 683-692. [Online] [Accessed on 12th October 2017]
<http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2834.2011.01268.x/full>

Morrow, S. L. (2006) 'Honor and respect: feminist collaborative research with sexually abused women.' In Fischer, C. T. (ed.) *Qualitative research methods for Psychologists: introduction through empirical studies*. Burlington: Academic Press, pp. 143-172.

Morse, J. (1994) Designing funded qualitative research. In Denzin, N. K. and Lincoln, Y. S. (eds.), *Handbook of Qualitative Research*. Thousand Oaks, California: SAGE Publications, pp. 220-235.

Moule, P. and Goodman, M. (2009) *Nursing research: an introduction*. Thousand Oaks, California: SAGE Publications.

Mulgan, R. (2000) 'Accountability': An ever-expanding concept?' Discussion Paper No. 72. The Australian National University. [Online] [Accessed on 12th June 2017]
https://openresearch-repository.anu.edu.au/bitstream/1885/41945/1/dp_72.htm

Munhall, P. L. (1982) 'Nursing philosophy and nursing research: in apposition or opposition?' *Nursing Research*, 31, pp. 176-181.

Munhall, P. L. (2012) *Nursing research: a qualitative perspective*. Sudbury, MA: Jones and Bartlett.

Natanson, M. (1973) *Edmund Husserl: philosophy of infinite tasks*. Evanston: Northwestern University Press.

National Patient Safety Agency. (2004) *Incident decision tree*. 1st February. NHS. [Online] [Accessed on 1st November 2016] <http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59900>

National Patient Safety Agency. (2006) *Risk assessment programme: overview*. London: The National Patient Safety Agency. [Online] [Accessed on 20th November 2016] <http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60102&>

Naude, M. and McCabe, R. (2005) 'Magnet hospital research pilot project conducted in hospitals in Western Australia.' *Contemporary Nurse*, 20(1), pp. 38-55.

Needle, D. (2010) *Business in context: an introduction to business and its environment*. Cengage Learning EMEA. [Online] [Accessed on 23rd January 2017] <https://ytnduringpdf.files.wordpress.com/2015/04/business-in-context-david-needle-pdf.pdf>

Needleman, J., Buerhaus, P., Pankratz, V. S., Leibson, C. L., Stevens, S. R. and Harris, M. (2011) 'Nurse staffing and inpatient hospital mortality.' *New England Journal of Medicine*, 364, pp.1037-45. [Online] [Accessed on 9th January 2017] <http://www.nejm.org/doi/full/10.1056/NEJMsa1001025#t=articleMethods>

Neenan, M. (2018) *Developing resilience: a cognitive-behavioural approach*. 2nd ed., London: Routledge. [Online] [Accessed on 13th October 2018] https://books.google.co.uk/books?hl=en&lr=&id=bkgrDwAAQBAJ&oi=fnd&pg=PP1&dq=resilience+weakness&ots=B4d0Y8U82x&sig=v86_zaaq66mrY_7bRjWi4rAch1s#v=onepage&q=resilience%20weakness&f=false

Neilson, G. and Lauder, W. (2008) 'What do high academic achieving school pupils really think about a career in nursing: analysis of the narrative from paradigmatic case interviews.' *Nurse Education Today*, 28, pp. 680-690. [Online] [Accessed on 12th October 2017] https://www.truthaboutnursing.org/research/lit/neilson_lauder.pdf

Nelms, T. P. (1996) 'Living a caring presence in nursing: a Heideggerian hermeneutical analysis.' *Journal of Advanced Nursing*, 24(2), pp. 368-374.

Neuman, L. (2000) *Social research methods: qualitative and quantitative approaches*. 4th ed., Boston: Allyn & Bacon.

Newcombe, T. (2013) *There is a culture of "fear and intimidation" in nursing*, RCN warns. 23rd April. HR. [Online] [Accessed on 3rd May 2017] <http://www.hrmagazine.co.uk/article-details/there-is-a-culture-of-fear-and-intimidation-in-nursing-rcn-warns>

NHS Improvement. (2017) *Single Oversight Framework: appendices*. Publication details not available. [Online] [Accessed on 27th November 2017] <https://improvement.nhs.uk/resources/single-oversight-framework/>

NHS Leadership Academy. (2011) *Leadership framework: a summary*. Coventry: NHS Institute for Innovation and Improvement. [Online] [Accessed on 10th June 2017] <http://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Framework-LeadershipFramework-Summary.pdf>

NHS Leadership Academy. (2013a) *The Healthy NHS Board Principles for Good Governance* [Online] [Accessed on 10th June 2017] <https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-TheHealthyNHSBoard.pdf>

NHS Leadership Academy. (2013b) *Healthcare leadership model: the nine dimensions of leadership behaviour*. Leeds: NHS Leadership Academy. [Online] [Accessed on 10th June 2017] http://www.leadershipacademy.nhs.uk/wp-content/uploads/dlm_uploads/2014/10/NHSLeadership-LeadershipModel-colour.pdf

NHS Leadership Academy. (2014) *Healthcare Leadership Model: Helping you to become a better leader* [Online] [Accessed on 10th June 2017] <http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/>

NHS Leadership Academy. (2015) *Developing better leaders, delivering better care*. [Online] [Accessed on 10th June 2017] <http://www.leadershipacademy.nhs.uk/>

NHS Survey Co-ordination Centre. (2016) *Results for the 2016 NHS Staff Survey*. NHS. [Online] [Accessed on 8th December 2016]

<http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2015-Results/>

Nicholson, D. (2012) Letter to all NHS Trust Chairs and all NHS Foundation Trust Chairs. [Online] [Accessed on 23rd June 2017] <http://tinyurl.com/cbkg8wa>

Nightingale, F. (1849, reprinted 1946) *Notes on nursing: what it is, and what it is not*. Philadelphia: Lippincott. [Online] [Accessed on 3rd February 2017]

<https://archive.org/details/notesnursingwhat00nigh>

Nuffield Trust. (2015) *Nuffield Trust responds to nurse shortage warning*. 10th September. Nuffield Trust. [Online] [Accessed on 16th June 2017]

https://www.nuffieldtrust.org.uk/news-item/nuffield-trust-responds-to-nurse-shortage-warning?gclid=Cj0KEQjwg47KBRDk7LSu4LTD8eEBEiQAO4O6r0djxzhbmhsjn5-6a03w2qE_a0bHEDM5H1eH86dVGUgaAt5C8P8HAQ

Nursing and Midwifery Council. (2008) *The Code: Standards of conduct, performance and ethics for nurses and midwives*. London: NMC. [Online] [Accessed on 13th January 2016]

<https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-old-code-2008.pdf>

Nursing and Midwifery Council. (2010) *Standards for pre-registration nursing education*. London: NMC. [Online] [Accessed on 20th September 2017]

<https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-pre-registration-nursing-education.pdf>

Nursing and Midwifery Council. (2013) *NMC response to the Francis Report: the response of the Nursing and Midwifery Council to the Mid Staffordshire NHS Foundation Trust Public Inquiry report*. London: NMC. [Online] [Accessed on 25th March 2015] <https://www.nmc.org.uk/globalassets/sitedocuments/francis-report/nmc-response-to-the-francis-report-18-july.pdf>

Nursing and Midwifery Council. (2015a) *The code: professional standards of practice and behaviour for nurses and midwives*. London: NMC. [Online] [Accessed on 13th January 2016] <https://www.nmc.org.uk/standards/code/>

Nursing and Midwifery Council. (2015b) *The NMC code: professional staff, quality services*. London: NMC. [Online] [Accessed on 28th July 2017] <https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code-employers.pdf>

Nursing and Midwifery Council. (2016) *Programme of change for education: modernising education standards*. [Online] [Accessed on 24th July 2017] <https://www.nmc.org.uk/education/programme-of-change-for-education/>

Nursing and Midwifery Council. (2017a) *The NMC register 2012/13 - 2016/17*. London: NMC. [Online] [Accessed on 25th July 2017] <https://www.nmc.org.uk/globalassets/sitedocuments/other-publications/nmc-register-2013-2017.pdf>

Nursing and Midwifery Council. (2017b) *Health Committee: accountability to the Health Select Committee*. [Online] [Accessed on 10th October 2017] <https://www.nmc.org.uk/about-us/oversight/health-committee/>

Nursing and Midwifery Council. (2017c) *Education framework: standards for education and training: for all United Kingdom providers of nursing and midwifery education*. [Online] [Accessed on 19th December 2017] <https://www.nmc.org.uk/globalassets/sitedocuments/edcons/ec4-draft-education-framework--standards-for-education-and-training.pdf>

Nyatanga, B. (2012) 'Caring about culture.' *British Journal of Community Nursing*, 17(4), p. 153. [Online] [Accessed on 3rd August 2017] <http://www.magonlinelibrary.com/doi/full/10.12968/bjcn.2012.17.4.153>

Omery, A. (1983) 'Phenomenology: a method for nursing research.' *Advances in Nursing Science*, 5(2), pp. 49-64. [Online] [Accessed on 20th December 2014] http://journals.lww.com/advancesinnursingscience/Citation/1983/01000/Phenomenology_a_method_for_nursing_research.10.aspx

Ortiz, M. R. (2009) 'Hermeneutics and nursing research: history, processes, and exemplar.' *Southern Online Journal of Nursing Research*, 9(1). [Online] [Accessed on 26th September 2016]

www.resourcenter.net/images/snrs/files/sojnr_articles2/vol09num01art01.html

Oulton, J. (2000) 'Inside view.' *International Nursing Review*, 47(3), pp. 137-141. [Online] [Accessed on 20th January 2017]

<http://onlinelibrary.wiley.com/doi/10.1046/j.1466-7657.2000.00031.x/full>

Padgett, S. M. (2000) 'Benner and the critics: promoting scholarly dialogue.' *Scholarly Inquiry for Nursing Practice*, 14(3), pp. 249-266.

Padgett, S. M. (2013) 'Professional collegiality and peer monitoring among nursing staff: an ethnographic study.' *International Journal of Nursing Studies*, 50(10), pp. 1407-1415. [Online] [Accessed on 28th November 2016]

<http://doi.org/10.1016/j.ijnurstu.2012.12.022>

Paley, J. (1997) 'Husserl, phenomenology and nursing.' *Journal of Advanced Nursing*, 26(1), pp. 187-193. [Online] [Accessed on 24th June 2015]

<http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.1997.1997026187.x/pdf>

Paley, J. (1998) 'Misinterpretive phenomenology: Heidegger, ontology and nursing research.' *Journal of Advanced Nursing*, 27(4), pp. 817-824.

Paley, J. (2013) 'Cognition and the compassion deficit: the social psychology of helping behaviour in nursing.' *Nursing Philosophy*, 15(4), pp. 274-287. [Online] [Accessed on 22nd December 2016]

<http://onlinelibrary.wiley.com.ezproxy.mmu.ac.uk/doi/10.1111/nup.12047/full>

Parahoo, K. (2006) *Nursing research: principles, process and issues*. 2nd ed., Basingstoke: Palgrave Macmillan.

Parse, R. R. (2001). *Qualitative inquiry: The path of sciencing* (No. 14). Jones & Bartlett Learning.

Paterson, M. and Higgs, J. (2005) 'Using hermeneutics as a qualitative research approach in professional practice.' *The Qualitative Report*, 10(2), pp. 339-357. [Online] [Accessed on 23rd June 2017] <http://nsuworks.nova.edu/tqr/vol10/iss2/9>

Pattison, S. (2001) 'Are nursing codes of practice ethical?' *Nursing Ethics*, 8(1), pp. 5-18. [Online] [Accessed on 20th January 2016] <http://learn.niu.edu/uhrs410/docs/Nursing/NursingPattison.pdf>

Payton, F. C., Pare, G., Le Rouge, C. and Reddy, M. (2011) 'Health care IT: process, people, patients and interdisciplinary considerations.' *Journal of the Association for Information Systems*, 12(2), Article 4. [Online] [Accessed on 26th February 2017] <https://ai2-s2-pdfs.s3.amazonaws.com/efb5/2fe8f112b342c04c792870a618586fdc1d2c.pdf>

Peate, I. (2015) *The NMC may be doing better, but it's still failing*. 12th August. British Journal of Nursing. [Online] [Accessed on 12th March 2017] <http://www.magonlinelibrary.com/doi/10.12968/bjon.2015.24.15.767>

Pellegrino, E. D. (2002) 'Professionalism, profession and the virtues of the good physician.' *Mount Sinai Journal of Medicine*, 69(6), pp. 378-384.

Peters, T. and Waterman, R. H. (1982) *In search of excellence*. London: Harper and Row.

Pines, E. W., Rauschhuber, M. L., Norgan, G. H., Cook, J. D., Canchola, L., Richardson, C. and Jones, M. E. (2012) 'Stress resiliency, psychological empowerment and conflict management styles among baccalaureate nursing students.' *Journal of Advanced Nursing*, 68(7), pp. 1482-1493. [Online] [Accessed on 12th October 2017] <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2648.2011.05875.x/full>

Pines, E. W., Rauschhuber, M. L., Cook, J. D., Norgan, G. H., Canchola, L., Richardson, C., and Jones, M. E. (2014) 'Enhancing resilience, empowerment, and conflict management among baccalaureate students: outcomes of a pilot study.' *Nurse Educator*, 39(2), pp. 85-90. [Online] [Accessed on 12th October 2017] DOI:10.1097/NNE.0000000000000023

Pfeiffer, P. N., Heisler, M., Piette, J. D., Rogers, M. A. and Valenstein, M. (2011) 'Efficacy of peer support interventions for depression: a meta-analysis.' *General Hospital Psychiatry*, 33(1), pp. 29-36. [Online] [Accessed on 21st July 2017]
http://www.sciencedirect.com.ezproxy.mmu.ac.uk/science/article/pii/S0163834310001982?_rdoc=1&_fmt=high&_origin=gateway&_docanchor=&md5=b8429449ccfc9c30159a5f9aeaa92ffb&_ccp=y

Phipps, A. (1993) 'A phenomenological study of couples' infertility: gender influence.' *Holistic Nursing Practice*, 7(2), pp. 44-56.

Polifroni, E. C. and Welsh, M. (2004) *Perspectives on philosophy of science in Nursing: an historical and contemporary anthology*. Philadelphia: Lipincott, pp. 263-272.

Polit, D. F. and Beck, C. T. (2009) *Nursing research: principles and methods*. 7th ed., Philadelphia: Lippincott, Williams & Wilkins.

Pollitt, C. (1990) *Managerialism and the public services: the Anglo-American experience*. Oxford: Blackwell.

Pollitt, C. (2003) *The essential public manager*. London: Open University Press/McGraw-Hill.

Price, B. (2006) 'Exploring person-centred care.' *Nursing Standard*, 20(50), pp. 49-56. [Online] [Accessed on 20th September 2016]
<http://journals.rcni.com/doi/pdfplus/10.7748/ns2006.08.20.50.49.c4487>

Priest, H. (2004) 'Phenomenology.' *Nurse Researcher*, 11(4), pp. 4-6. [Online]
[Accessed on 22nd April 2014]
<http://go.galegroup.com.ezproxy.mmu.ac.uk/ps/i.do?action=interpret&v=2.1&u=mmu-cal5&it=Jlourl&issn=1351-5578&p=AONE&sw=w&authCount=1>

Professional Standards Authority for Health and Social Care. (2013) *Annual report and accounts and performance review report 2012-13. Volume I: Annual report and accounts 2012-13*. London: TSO. [Online] [Accessed on 1st February 2017]
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/246692/0305.pdf

Professional Standards Authority for Health and Social Care. (2014) *Annual report and accounts and performance review report 2013/14. Volume II: Performance review report 2013/14*. London: TSO. [Online] [Accessed on 1st February 2017]
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/328077/Professional_Standards_Authority_Volume_II.pdf

Professional Standards Authority for Health and Social Care. (2015) *Annual report and accounts and performance review report 2014/2015. Volume II: Performance Review Report 2014/2015*. [Online] [Accessed on 1st February 2017]
https://www.professionalstandards.org.uk/docs/default-source/publications/performance-reviews/performance-review-report-2014-2015.pdf?sfvrsn=1287f20_12

Professional Standards Authority for Health and Social Care. (2017) *Terms of reference for review of Nursing and Midwifery Council announced*. 15th June. [Online] [Accessed on 10th October 2017]
<http://www.professionalstandards.org.uk/latest-news/latest-news/detail/2017/06/15/terms-of-reference-for-review-of-nursing-and-midwifery-council-announced>

Pupkiewicz, J., Kitson, A. and Perry, J. (2015) 'What factors within the peri-operative environment influence the training of scrub nurses?' *Nurse Education in Practice*, 15(5), pp. 373-380. [Online] [Accessed on 20th December 2016]
<http://www.sciencedirect.com/science/article/pii/S1471595315000505>

Purtilo, R. B. and Cassel, C. K. (1981) *Ethical dimensions in the health care professions*. Philadelphia: WB Saunders.

Queen's Nursing Institute. (2014) *2020 Vision - 5 years on: reassessing the future of District Nursing*. [Online] [Accessed on 6th February 2017]
http://www.qni.org.uk/docs/2020_Vision_Five_Years_On_Web1.1.pdf

Rabinow, P. and Sullivan, W. *Interpretative social science: a second look*. Berkeley: University of California Press, pp. 327-350.

Raklow, L. (2011) 'Commentary: interviews and focus groups as critical and cultural methods.' *Journalism & Mass Communication Quarterly*, 88(2), pp. 416-428. [Online] [Accessed on 26th September 2016]
https://www.researchgate.net/profile/Lana_Rakow2/publication/254120594_Commentary_Interviews_and_Focus_Groups_as_Critical_and_Cultural_Methods/links/0c96053cd4652d32d2000000.pdf

Randle, J. (2003) 'Bullying in the nursing profession.' *Journal of Advanced Nursing*, 43(4), pp. 395-401. [Online] [Accessed on 4th January 2018]
<http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.2003.02728.x/full>

Ranmuthugala, G., Plumb, J. J., Cunningham, F. C., Georgiou, A., Westbrook, J. I. and Braithwaite, J. (2011) 'How and why are communities of practice established in the healthcare sector? A systematic review of the literature.' *BMC Health Services Research*, 11. [Online] [Accessed on 15th March 2017]
<https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-11-273>

Reason, J. T. (1997) *Managing the risks of organizational accidents*. Aldershot: Ashgate.

Reid, A. J. (1996) 'What we want: qualitative research. Promising frontier for family medicine.' *Canadian Family Physician*. 42, pp. 387-389. [Online] [Accessed on 25th August 2015]
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2146303/pdf/canfamphys00073-0017.pdf>

Reiners, G. M. (2012) 'Understanding the differences between Husserl's (Descriptive) and Heidegger's (Interpretive) Phenomenological Research.' *Journal of Nursing Care*, 1(5). [Online] [Accessed on 4th May 2017]

<https://www.omicsgroup.org/journals/understanding-the-differences-husserls-descriptive-and-heideggers-interpretive-phenomenological-research-2167-1168.1000119.pdf>

Research Councils UK. (2017) [Online] [Accessed on 20th August 2017]

<http://www.rcuk.ac.uk/>

Research Councils UK. (2017) *Research Outcomes Overview*. [Online] [Accessed on 21st October 2017] <http://www.rcuk.ac.uk/research/researchoutcomes/>

Ricoeur, P. (1978) *The rule of metaphor: multi-disciplinary studies of the creation of meaning in language*. London: Routledge.

Roberts, M. and Ion, R. (2015) 'Thinking critically about the occurrence of widespread participation in poor nursing care.' *Journal of Advanced Nursing*, 71(4), pp. 768-776. [Online] [Accessed on 22nd December 2016]

<http://onlinelibrary.wiley.com/doi/10.1111/jan.12586/full>

Roberts, S. J. (1983) 'Oppressed group behaviour: implications for nursing.' *Advances in Nursing Science*, 5(4), pp. 21-30.

Robstad N., Söderhamn U., and Fegran, L. (2017) 'Intensive care nurses' experiences of caring for obese intensive care patients: a hermeneutic study.'

Journal of Clinical Nursing, 27(1-2), pp. 386-395. [Online] [Accessed on 7th October 2017] <http://onlinelibrary.wiley.com/doi/10.1111/jocn.13937/full>

Rolfe, G. and Gardner, L. (2014) 'Invisible gorillas and red herrings: a response to Paley (2013).' *Nurse Education Today*, 34(6), pp. 954-957. [Online] [Accessed on 3rd January 2017] <http://garyrolfe.net/documents/1-s2.0-S0260691714000112-main.pdf>

Rolls, L. and Relf, M. (2006) 'Bracketing interviews: addressing methodological challenges in qualitative interviewing in bereavement and palliative care, mortality.' 11(3), pp. 286-305. [Online] [Accessed on 12th January 2018]

<http://www.tandfonline.com/doi/abs/10.1080/13576270600774893>

Rowe, M. M. and Sherlock, H. (2005) 'Stress and verbal abuse in nursing: do burned out nurses eat their young?' *Journal of Nursing Management*, 13(3), pp. 242-248. [Online] [Accessed on 8th December 2016]

<http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2834.2004.00533.x/full>

Royal College of Midwives. (2017) *NMC 'to be investigated' over Morecambe Bay*. 20th February. [Online] [Accessed on 30th June 2017] <https://www.rcm.org.uk/news-views-and-analysis/news/nmc-to-be-investigated-over-morecambe-bay>

Royal College of Nursing. (2004) *Interpreting accountability: an ethnographic study of practice nurses, accountability and multidisciplinary team decision making in the context of clinical governance*. London: Royal College of Nursing. [Online] [Accessed on 4th September 2017] <https://www.rcn.org.uk/professional-development/publications/pub-002249>

Royal College of Nursing. (2011) *Research ethics: RCN guidance for nurses*. London: Royal College of Nursing. [Online] [Accessed 25th September 2014] <https://www.rcn.org.uk/professional-development/publications/pub-003138>

Royal College of Nursing. (2016) *Skill-mix risks identified*. 15th November. Royal College of Nursing. [Online] [Accessed on 16th June 2017] <https://www.rcn.org.uk/news-and-events/news/skill-mix-risks-identified>

Royal College of Nursing. (2017a) *Brexit - the implications for EEA workers, students and family members*. Royal College of Nursing. [Online] [Accessed on 2nd June 2017] <https://www.rcn.org.uk/get-help/rcn-advice/brexit-implications>

Royal College of Nursing. (2017b) *Accountability and delegation* [Online] [Accessed on 16th June 2017] <https://www.rcn.org.uk/professional-development/accountability-and-delegation>

Royal College of Nursing. (2017c) *Clinical supervision: advice guide*. [Online] [Accessed on 7th February 2017] <https://www.rcn.org.uk/get-help/rcn-advice/clinical-supervision>

Sadri, G. (2012) 'Emotional intelligence and leadership development.' *Public Personnel Management*, 41(3), pp. 535-548. [Online] [Accessed on 12th October 2017] <https://www.questia.com/library/journal/1G1-302299431/emotional-intelligence-and-leadership-development>

Salovey, P. and Mayer, J. D. (1990) 'Emotional intelligence.' *Imagination, Cognition and Personality*, 9(3), pp. 185-211. [Online] [Accessed on 12th October 2017] <http://dmcodyssey.org/wp-content/uploads/2013/09/EMOTIONAL-INTELLIGENCE-3.pdf>

Sandelowski, M. (1986) 'The problem of rigor in qualitative research.' *Advances in Nursing Science*, 8(3), pp. 27-37.

Sandelowski, M. (1993) 'Rigor or rigor mortis: the problem of rigor in qualitative research revisited.' *Advances in Nursing Science*, 16(2), pp. 1-8.

Sandelowski, M. (2002) 'Re-embodiment qualitative research.' *Qualitative Health Research*, 12(1), pp. 104-115. [Online] [Accessed on 6th June 2016] <http://qhr.sagepub.com/content/12/1/104.long?hwshib2=authn%3A1465302737%3A20160606%253A6737eb81-34d3-4089-a6a02a1037f290a4%3A0%3A0%3A0%3AFPateWWSysjtEOkKQ2vN%2Fg%3D%3D>

Santry, C. (2011) 'Understanding' nurses accept bullying and abuse but want to leave on time. 5th September. *Nursing Times*. [Online] [Accessed on 6th February 2017] <http://www.nursingtimes.net/nursingpractice/clinical-specialisms/management/understanding-nurses-accept-bullyingand-abuse-but-want-to-leave-on-time/5033526.article>

Savin-Baden, M. (2004) 'Achieving reflexivity: moving researchers from analysis to interpretation in collaborative inquiry.' *Journal of Social Work Practice*, 18(3), pp. 365-378. [Online] [Accessed on 10th June 2015] <http://www.tandfonline.com/doi/pdf/10.1080/0265053042000314438?instName=Manchester+Metropolitan+University>

Scally, G and Donaldson, L. J. (1998) 'The NHS's 50 anniversary. Clinical governance and the drive for quality improvement in the new NHS in England.' *British Medical Journal*, 317(7150), pp. 61-65.

Schein, E. H. (1990) *Organizational culture*. *American Psychologist*, 45, 109-119 [Online] [Accessed on 25th January 2017]
[http://ciow.org/docsB/Schein\(1990\)OrganizationalCulture.pdf](http://ciow.org/docsB/Schein(1990)OrganizationalCulture.pdf)

Schmalenberg, C. and Kramer, M. (2008) 'Essentials of a productive nurse work environment.' *Nursing Research*, 57(1), pp. 2-13. [Online] [Accessed on 15th November 2016] DOI:10.1097/01.NNR.0000280657.04008.2a

Schreuder, J. A. H., Roelen, C., van Zweeden, N. F., Jongsma, D., van der Klink, J. J. L. and Groothoff J. W. (2011) 'Leadership styles of nurse managers and registered sickness absence among their nursing staff.' *Health Care Management Review*, 36(1), pp. 58-66. [Online] [Accessed on 18th July 2017]
https://www.researchgate.net/profile/Nely_Zweeden/publication/49682599_Leadership_styles_of_nurse_managers_and_registered_sickness_absence_among_their_nursing_staff/links/562f6aaa08ae4742240acd65/Leadership-styles-of-nurse-managers-and-registered-sickness-absence-among-their-nursing-staff.pdf

Scott, S. D. and Estabrooks, C. A. (2006) 'Mapping the organizational culture research in nursing: a literature review.' *Journal of Advanced Nursing*, 56(5), pp. 498-513. [Online] [Accessed on 2nd November 2016]
https://www.researchgate.net/profile/Shannon_Scott3/publication/6717409_Mapping_the_organizational_culture_research_in_nursing_A_literature_review/links/0fcfd5126a713581c2000000/Mapping-the-organizational-culture-research-in-nursing-A-literature-review.pdf

Segrott, J., McIvor, M. and Green, B. (2006) 'Challenges and strategies in developing nursing research capacity: a review of the literature.' *International Journal of Nursing Studies*, 43(5), pp. 637-651.

Shinyashiki, G. T., Mendes, I., Trevizan, M., and Day, R. A. (2006) 'Professional socialization: students becoming nurses.' *Revista Latino-Americana de Enfermagem*, 14(4), pp. 601-607. [Online] [Accessed on 15th June 2017]

http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-11692006000400019&lng=en&nrm=iso&tlng=en

Silverman, D. (2013) *Doing qualitative research*. 4th ed., Los Angeles: SAGE Publications.

Simons, S. R. (2008) 'Workplace bullying experienced by Massachusetts registered nurses and the relationship to intention to leave the organization.' *Advanced Nursing Science*, 31 (2), pp. 48-59. DOI: 10.1097/01.ANS.0000319571.37373.d7

Siriwardena, A. N. (2006) 'Releasing the potential of health services: translating clinical leadership into healthcare quality improvement.' *Quality in Primary Care*, 14, pp. 125-128. [Online] [Accessed on 18th April 2016]

http://eprints.lincoln.ac.uk/3370/1/Siriwardena_Releasing_the_potential_of_health_services_QPC_2006.pdf

Smith, J. A. and Osborn, M. (2008) 'Interpretative Phenomenological Analysis.' In Smith, J. A. (ed.), *Qualitative psychology: a practical guide to research methods*. 2nd ed., London: SAGE Publications, pp. 53-80.

Smith, J. A., Flowers, P. and Larkin, M. (2009) *Interpretative Phenomenological Analysis: theory, method and research*. London: SAGE Publications.

Smith, J. A. and Osborn, M. (2003) 'Interpretative phenomenological analysis.' In Smith, J. A. (ed.) *Qualitative psychology: a practical guide to research methods*. London: SAGE Publications.

Smith, P. (1992) *The emotional labour of nursing*. London: Macmillan.

Smythe, E. A., Ironside, P. M., Sims, S. L., Swenson, M. M., and Spence, D. G. (2008) 'Doing Heideggerian hermeneutic research: a discussion paper.' *International Journal of Nursing Studies*, 45(9), pp. 1389-1397.

Solomon, J. L. (1987) *From Hegel to existentialism*. New York: Oxford University Press.

Sorensen, E. E., Seebeck, E. D., Scherb, C. A., Specht, J. P. and Loes, J. L. (2009) 'The relationship between RN job satisfaction and accountability.' *Western Journal of Nursing Research*, 31(7), pp. 872-888. [Online] [Accessed on 22nd July 2017] <http://journals.sagepub.com/doi/pdf/10.1177/0193945909340567>

Sorensen, R. and Iedema, R. (2009) 'Emotional labour: clinicians' attitudes to death and dying.' *Journal of Health Organization and Management*, 23(1), pp. 5-22. [Online] [Accessed on 19th August 2017] http://www.iresearch4birth.eu/iResearch4Birth/resources/cms/documents/NEW_KB_Emotional_labour_clinicians_attitude_to_death_and_dying.pdf

Spector, P. E. (2006) *Industrial and organizational psychology: research and practice*. 4th ed., New Jersey: Wiley.

Spence-Laschinger, H. K., Borgogni, L., Consiglio, C. and Read, E. (2015) 'The effects of authentic leadership, six areas of work life, and occupational coping self-efficacy on new graduate nurses' burnout and mental health: a cross-sectional study.' *International Journal of Nursing Studies*, 52(6), pp. 1080-1089. [Online] [Accessed on 11th January 2017] <http://www.sciencedirect.com/science/article/pii/S0020748915000644>

Spiegelberg, H. (1975) *Doing phenomenology: essays on and in phenomenology*. The Hague: Martinus Hijhoff.

Spurgeon, P., Flanagan, H., Cooke, M., Sujan, M., Cross, S. and Jarvis, R. (2017) 'Creating safer health systems: lessons from other sectors and an account of an application in the Safer Clinical Systems programme.' *Health Services Management Research*, 30(2), pp. 85-93.

Stacey, G., Pollock, K. and Crawford, P. (2016) 'The rules of the game in graduate entry nursing: a longitudinal case study.' *Nurse Education Today*, 36, pp. 184-189. [Online] [Accessed on 15th June 2017]

https://www.researchgate.net/profile/Kristian_Pollock/publication/283207763_The_rules_of_the_game_in_graduate_entry_nursing_A_longitudinal_case_study/links/56d3653908ae85c8234c6f80.pdf

Stanley, K. M., Martin, M. M., Michel, Y., Welton, J. M. and Nemeth, L. S. (2007) 'Examining lateral violence in the nursing workforce.' *Issues in Mental Health Nursing*, 28(11), pp. 1247-1265. [Online] [Accessed on 9th October 2017]
<http://www.tandfonline.com/doi/full/10.1080/01612840701651470?needAccess=true&instName=Manchester+Metropolitan+University>

Stayt, L. C. (2009) 'Death, empathy and self-preservation: the emotional labour of caring for families of the critically ill in adult intensive care.' *Journal of Clinical Nursing*, 18(9), pp. 1267-1275. [Online] [Accessed on 17th February 2017]
<http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2702.2008.02712.x/full>

Stogdill, R. M. (1974) *Handbook of leadership: a survey of theory and research*. New York: Free Press.

Stone, P. W., Mooney-Kane, C., Larson, E. L., Pastor, D. K., Zwanziger, J. and Dick, A. W. (2007) 'Nurse working conditions, organizational climate, and intent to leave ICUs: an instrumental variable approach.' *Health Services Research*, 42(3), pp. 1085-1104. DOI: 10.1111/j.1475-6773.2006.00651.x

Strasser, P. B., Hutton, S., and Gates, D. (2008) 'Workplace incivility and productivity losses among direct care staff.' *AAOHN*, 56(4), pp. 168-175. [Online] [Accessed on 7th October 2017]
<http://journals.sagepub.com/doi/pdf/10.1177/216507990805600405>

Stubblefield, C., and Murray, R. L. (2002). A phenomenological framework for psychiatric nursing research. *Archives of psychiatric nursing*, 16(4), 149-155. [Online] [Accessed on 15th February 2017] <https://ac.els-cdn.com/S0883941702000018/1-s2.0-S0883941702000018-main.pdf?tid=3fafbccf-e0e7-445a-acda-322d25991c8b&acdnat=154194866355c4eef3989df245d3c050933b9afa04>

Summers, S. and Summers, H. J. (2009) *Saving lives: why the media's portrayal of nurses puts us all at risk*. New York: Kaplan.

Suominen, T., Kovasin, M., and Ketola, O. (1997) 'Nursing culture — some viewpoints.' *Journal of Advanced Nursing*, 25(1), pp. 186-190. [Online] [Accessed on 27th October 2017] <http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.1997.1997025186.x/pdf>

Sutherland, A. M. and Dodd, F. (2008) 'NHS Lanarkshire's leadership development programme's impact on clinical practice.' *International Journal of Health Care Quality Assurance*, 21(6), pp. 569-84. [Online] [Accessed on 4th October 2017] [DOI:10.1108/09526860810900727](https://doi.org/10.1108/09526860810900727)

Swanson, K. M. and Wojnar, D. (2004) 'Optimal healing environments in nursing.' *Journal of Alternative and Complementary Medicine*, 10(S1), S43-S48. [Online] [Accessed on 12th December 2016] <https://pdfs.semanticscholar.org/9d6b/e4b6d47531e506fbcfb0874ab3dd469ea8aa.pdf>

Swift, C. (2015) 'Omitting spirituality from NMC code disadvantages our patients.' *Nursing Standard*, 29(38), pp. 32-33. [Online] [Accessed on 3rd August 2017] <http://dx.doi.org/10.7748/ns.29.38.32.s37>

Tadd, W., Clarke, A. and Lloyd, L., (2006) 'The value of nurses' codes: European nurses' views.' *Nursing Ethics*, 13(4), pp. 376-93.

Tajfel, H. and Turner, J. C. (1986) 'The social identity theory of intergroup behaviour.' In Worchel S. & Austin L.W., (eds.), *Psychology of Intergroup Relations*. Chicago: Nelson-Hall, pp. 7-24.

Takase, M., Maude, P. and Manias, E. (2006) 'Impact of the perceived public image on nurses' work behaviour.' *Journal of Advanced Nursing*, 53(3), pp. 333-343.

Takase, M., Kershaw, E. and Burt, L. (2002) 'Does public image of nurses matter?' *Journal of Professional Nursing*, 18(4), pp. 196-205.

Taylor, K. (2009) 'Phenomenological interpretation of Descartes.' *Journal of Undergraduate Research*, XII. [Online] [Accessed on 29th November 2017]
<https://www.uwlax.edu/urc/jur-online/PDF/2009/taylor-kristinPHI.pdf>

Taylor, K. (2016) 'Using shared governance to empower nurses.' *Nursing Times*, 112(1-2), pp. 20-23.

Taylor, R. (2016) *Emotional resilience shouldn't become a stick to beat social workers with*. 6th June. Community Care. [Online] [Accessed on 12th October 2017]
<http://www.communitycare.co.uk/2016/06/06/emotional-resilience-shouldnt-become-stick-beat-social-workers/>

Taylor, S. J. and Bogdan, R. (1984) *Introduction to qualitative research methods: the search for meanings*. 2nd ed., New Jersey: John Wiley.

Ten Hoeve, Y., Jansen, G. and Roodbol, P. (2013) 'The nursing profession: public image, self-concept and professional identity. A discussion paper.' *Journal of Advanced Nursing*, 70(2), pp. 295–308. [Online] [Accessed on 15th June 2017] DOI: 10.1111/jan.12177

Tetley, J., Grant, G. and Davies, S. (2009) 'Using narratives to understand older people's decision-making processes.' *Qualitative Health Research*, 19(9), pp. 1273-1283. [Online] [Accessed on 30th November 2017]
<https://pdfs.semanticscholar.org/fa10/cc6c6ba149dd64dc5b9c5245a7ee1124cd0a.pdf>

Thames, B. (2005) *Gadamer's Hermeneutical Ethics: an ethics of life. A seminar paper*. [Online] [Accessed on 2nd January 2017]
<http://www3.nd.edu/~bthames/docs/Gadamer's%20Ethics--Bradley%20J%20Thames.pdf>

- Thomas, C. M. (2010) 'Teaching nursing students and newly registered nurses strategies to deal with violent behaviours in the professional practice environment.' *The Journal of Continuing Education in Nursing*, 41(7), pp. 299-308. [Online] [Accessed on 17th June 2017] <http://dx.doi.org/10.3928/00220124-20100401-09>
- Thompson, J. (1990) 'Hermeneutic inquiry.' In Moody, E. (ed.), *Advancing Nursing Science Through Research, Volume 2*. Newbury Park: SAGE Publications, pp. 223-286.
- Tourangeau, A. N. N., Cranley, L., SPENCE LASCHINGER, H. K., & Pachis, J. (2010). Relationships among leadership practices, work environments, staff communication and outcomes in long-term care. *Journal of nursing management*, 18(8), 1060-1072. [Online] [Accessed 3rd November 2017] <https://pdfs.semanticscholar.org/58a2/8c62a6e092ebe7fde9b8071dc7caae962fa1.pdf>
- Tradewell, G. (1996) 'Rites of passage. Adaptation of nursing graduates to a hospital setting.' *Journal of Nursing Staff Development*, 12(4), pp. 183-189.
- Traynor M (2017) *Critical Resilience for Nurses: An Evidence-Based Guide to Survival and Change in the Modern NHS*. Routledge, Abingdon.
- Traynor, M. and Buus, N. (2016) 'Professional identity in nursing: UK students' explanations for poor standards of care.' *Social Science & Medicine*, 166, pp. 186-194. [Online] [Accessed on 10th October 2017] <http://www.sciencedirect.com/science/article/pii/S0277953616304464>
- Tufford, L. and Newman, P. (2010) 'Bracketing in qualitative research.' *Qualitative Social Work*, 11(1), pp. 80-96. [Online] [Accessed on 12th January 2018] <http://journals.sagepub.com/doi/full/10.1177/1473325010368316>
- Tusaie, K. and Dyer, K. (2004) 'Resilience: a historical review of the construct.' *Holistic Nursing Practice*, 18(1), pp. 3-8.

Twigg, D. and McCullough, K. (2014) 'Nurse retention: a review of strategies to create and enhance positive practice environments in clinical settings.' *International Journal of Nursing Studies*, 51(1), pp. 85-92. [Online] [Accessed on 24th March 2017] DOI: 10.1016/j.ijnurstu.2013.05.015.

Tzeng, H. M. (2006) 'Testing a conceptual model of the image of nursing in Taiwan.' *International Journal of Nursing Studies*, 43(6), pp. 755-765.

UK Public Spending. (2016) UK health care spending history from 1900. [Online] [Accessed on 13th September 2016] http://www.ukpublicspending.co.uk/healthcare_spending

United Kingdom Central Council. (1983) *Code of professional conduct for the nurse, midwife and health visitor*. London: HMSO.

United Kingdom Central Council. (1984) *Annual Report of the Council 1983-1984*. London: UKCC.

United Kingdom Central Council. (1986) *Project 2000: a new preparation for practice*. London: HMSO.

United Kingdom Central Council. (1992) *Code of professional conduct*. London: HMSO.

UKCRC Workforce Careers (Nursing) Group. (2006) *Developing the best research professionals*. London: UK Clinical Research Collaboration.

Ungar, M. (2008) 'Resilience across cultures.' *The British Journal of Social Work*, 38(2), pp. 218-235. [Online] [Accessed on 15th November 2016] <https://academic.oup.com/bjsw/article/doi/10.1093/bjsw/bcl343/1684596/Resilience-across-Cultures>

Urgent and Emergency Care Review Team. (2013) Urgent and Emergency Care Review - Evidence Base Engagement Document. Publication details not available. [Online] [Accessed on 20th November 2016] <https://www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf>

- Valle, R. S. and King, M. (1979) *Existential-phenomenological alternatives for psychology*. Oxford: Oxford University Press, pp. 48-71.
- Van Maanen, J. and Schein, E. (1977) Toward a Theory of Organizational Socialization. *Organizational Socialization*. Massachusetts Institute of Technology [Online] [Accessed on 5th November 2016]
<http://dspace.mit.edu/bitstream/handle/1721.1/1934/SWP-0960-03581864.pdf>
- Van Manen, M. (1984) Practicing Phenomenological Writing. *Phenomenology and Pedagogy*. Volume 2 Number 1 [Online] [Accessed on 13th May 2016]
<https://journals.library.ualberta.ca/pandp/index.php/pandp/article/view/14931/11752>
- Van Manen, M. (1990) *Researching lived experience*. New York: SUNY.
- Van Manen, M. (1997) *Researching the lived experience: human science for an action sensitive pedagogy*. 2nd ed., London, Ontario: Althouse Press.
- Van Manen, M. (2014). *Phenomenology of practice: meaning-giving methods in phenomenological research and writing*. Walnut Creek, CA: Left Coast Press.
- Van Teijlingen, E. and Ireland, J. (2003) Research interviews in midwifery. *Midwives* 6(6), pp. 260-263.
- Vanlaere, L. and Gastmans, C. (2007) 'Ethics in nursing education: learning to reflect on care practices.' *Nursing Ethics*, 14(6), pp. 758-766. [Online] [Accessed on 22nd March 2015] DOI: 10.1177/0969733007082116
- Veenstra, G. L., Ahaus, K., Welker, G. A., Heineman, E., van der Laan, M. J. and Muntinghe, F. L. H. (2016) 'Rethinking clinical governance: healthcare professionals' views: a Delphi study.' *British Medical Journal Open*, 7(1). [Online] [Accessed on 3rd June 2017] <http://bmjopen.bmj.com/content/7/1/e012591>
- Villeneuve, M. (1994) 'Recruiting and retaining men in nursing: a review of the literature.' *Journal of Professional Nursing*, 10(4), pp. 217-228.
- Vincent, C. (2010) *Patient safety*. 2nd ed., Oxford: Wiley-Blackwell.

Vincent, C., Burnett, S. and Carthey, J. (2014) 'Safety measurement and monitoring in healthcare: a framework to guide clinical teams and healthcare organisations in maintaining safety.' *British Medical Journal Quality and Safety*, 23, pp. 670-677.

[Online] [Accessed on 20th November 2016]

<http://qualitysafety.bmj.com/content/early/2014/04/23/bmjqs-2013-002757>

Wachter, B. (2009) *Hospital incident reporting systems: time to slay the beast*. 20th September. The Hospital Leader, blog of Society of Hospital Medicine. [Online]

[Accessed on 9th October 2017] <https://thehospitalleader.org/hospital-incident-reporting-systems-time-to-slay-the-monster/>

Wachter, R. M. (2013) 'Personal accountability in healthcare: searching for the right balance.' *British Medical Journal Quality & Safety*. [Online] 'Online first' published on 31st August 2012. [Accessed on 12th November 2016] <http://www.ajustnhs.com/wp-content/uploads/2012/06/accountability-and-patient-safety-2012.pdf>

Wagner, N. and Ronen, I. (1996) 'Ethical dilemmas experienced by hospital and community nurses: an Israeli survey.' *Nursing Ethics*, 3(4), pp. 294-304.

Wall, C., Glenn, S., Mitchinson, S., and Poole, H. (2004) 'Using a reflective diary to develop bracketing skills during a phenomenological investigation.' *Nurse Researcher*, 11(4), pp. 20-29. [Online] [Accessed on 29th November 2017]

<https://journals.rcni.com/doi/abs/10.7748/nr2004.07.11.4.20.c6212>

Wallach, E. (1983) 'Individuals and organization: the cultural match.' *Training and Development Journal*, 12, pp. 28-36.

Walsh, K. (1996) 'Philosophical hermeneutics and the project of Hans Georg: implications for nursing research.' *Nursing Inquiry*, 3(4), pp. 231-237.

Walters, A. J. (1995) 'A Heideggerian hermeneutic study of the practice of critical care nurses.' *Journal of Advanced Nursing*, 21, pp. 492-497. [Online] [Accessed on 29th November 2016] DOI: 10.1111/j.1365-2648.1995.tb02732.x

Waring, J. (2005) 'Beyond blame: cultural barriers to medical incident reporting.' *Social Science and Medicine*, 60(9), pp. 1927-1935. [Online] [Accessed on 6th October 2017]

[http://eprints.nottingham.ac.uk/737/2/Beyond blame - revision 1.pdf](http://eprints.nottingham.ac.uk/737/2/Beyond_blame_-_revision_1.pdf)

Waring, T. and Wainwright, D. (2008) 'Issues and challenges in the use of Template Analysis: two comparative case studies from the field.' *Electronic Journal of Business Research Methods*, 6(1), pp. 85-94. [Online] [Accessed on 20th February 2015] <http://www.ejbrm.com/issue/download.html?idArticle=187>

Warnock, M. (1970) *Existentialism*. Oxford University Press, Oxford

Watson, R. (2011) *We need the IV leaguers*. The Times Higher Education Supplement. 28th July. [Online] [Accessed on 15th June 2017] <https://www.timeshighereducation.com/news/we-need-the-iv-leaguers/416935.article>

Weaver, K. (2007) 'Ethical sensitivity: state of knowledge and needs for further research.' *Nursing Ethics*, 14(2), pp. 141-155. [Online] [Accessed on 5th October 2014] DOI: 10.1177/0969733007073694
<http://nej.sagepub.com/content/14/2/141.abstract>

Webb, C. (2003) 'Editor's note: introduction to guidelines on reporting qualitative research.' *Journal of Advanced Nursing*, 42(6), pp. 544-545. [Online] [Accessed on 25th September 2016] <http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.2003.02716.x/full>

Wedgery, A. (1966) 'The will to match our opportunity.' *The Canadian Nurse*, 62(6), pp. 35-39.

Weidman, J., Twale, D. J. and Stein, E. L. (2001) 'Socialization of graduate and professional students in higher education: a perilous passage?' *Ashe Eric Higher Education Report*, 28(3), pp. 1-118. [Online] [Accessed on 15th June 2017] <http://files.eric.ed.gov/fulltext/ED457710.pdf>

Weinstein D. (1979) *Bureaucratic opposition: challenging abuses at the workplace*. Oxford: Pergamon Press.

Wells, J. and Bowers, L. (2002) 'How prevalent is violence towards nurses working in general hospitals in the UK?' *Journal of Advanced Nursing*, 39(3), pp. 230-240. [Online] [Accessed on 8th December 2016] <http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.2002.02269.x/full>

Wenger, E. (2009) *Communities of practice: a brief introduction*. [Online] [Accessed on 19th July 2017] <http://neillthew.typepad.com/files/communities-of-practice.pdf>

West, M., Armit, K., L. Loewenthal, Eckart, R., West, T. and Lee, A. (2015) *Leadership and leadership development in health care: the evidence base*. London: Faculty of Medical Leadership and Management. [Online] [Accessed on 6th June 2017] https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/leadership-leadership-development-health-care-feb-2015.pdf

White, R. (1976) 'Some political influences surrounding the Nurses Registration Act 1919 in the United Kingdom.' *Journal of Advanced Nursing*, 1(3), pp. 209-217. [Online] [Accessed on 18th January 2017] <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2648.1976.tb00957.x/pdf>

Whitehead, P. B., Herbertson, R. K., Hamric, A. B., Epstein, E. G. and Fisher, J. M. (2015) 'Moral distress among healthcare professionals: report of an institution-wide survey.' *Journal of Nursing Scholarship*, 47(2), pp. 117-125. [Online] [Accessed on 9th January 2017]. DOI: 10.1111/jnu.12115

Whyte, L. and Gajos, M. (1996) 'A study of nurses' knowledge of the UKCC code of conduct.' *Nursing Standard*, 10(47), pp. 35-39.

Willems, T. and Van Dooren, W. (2012) 'Coming to terms with accountability: combining multiple forums and functions.' *Public Management Review*, 14(7), pp.1011-1036. [Online] [Accessed on 25th April 2017] <https://ecpr.eu/filestore/paperproposal/79d2738d-62e7-4991-a1af-6dcd19dccbca.pdf>

Williams, C. (1995) 'Hidden advantages for men in nursing.' *Nursing Administration Quarterly*, 19(2), pp. 63-70. [Online] [Accessed on 20th October 2014] <http://folk.uio.no/olegmo/Men%20in%20Nursing/Williams,%20C.1995.pdf>

Williams, C. (2006) *Leadership accountability in a globalizing world*. London: Palgrave Macmillan.

Willig, C. (2001) *Introducing qualitative research in psychology: adventures in theory and method*. Buckingham: Open University Press.

Willis, G. (2015) *Raising the bar. Shape of caring: a review of the future education and training of Registered Nurses and Care Assistants*. [Online] [Accessed on 24th July 2017] <https://www.hee.nhs.uk/sites/default/files/documents/2348-Shape-of-caring-review-FINAL.pdf>

Wilson, A. M. (2014) 'Mentoring student nurses and the educational use of self: a hermeneutic phenomenological study.' *Nurse Education Today*, 34(3), pp. 313-318. [Online] [Accessed on 5th May 2016] <http://oro.open.ac.uk/39478/1/Educational%20use%20of%20self-NET-for%20oro.pdf>

Wilson, H. S. and Hutchinson, S. A. (1991) 'Triangulation of qualitative methods: Heideggerian hermeneutics and grounded theory.' *Qualitative Health Research*, 1(2), pp. 263-276.

Witz, A. (1990) 'Patriarchy and professions: the gendered politics of occupational closure.' *Sociology*, 24(4), pp. 675-690.

Wojnar, D. M. and Swanson, K. M. (2007) 'Phenomenology: an exploration.' *Journal of Holistic Nursing*, 25(3), pp. 172-180. [Online] [Accessed on 27th June 2017] <https://pdfs.semanticscholar.org/2659/130c3ee429d3f390779dc3120cc416bd0497.pdf>

Wolin, R. (1990) *The politics of being: the political thought of Martin Heidegger*. Columbia: University Press.

Wolcott, H. (1990) *Writing up Qualitative research*, Newbury Park, CA : Sage

Wong, C. A. and Cummings, G. G. (2009) 'Authentic leadership: a new theory for nursing or back to basics?' *Journal of Health Organization and Management*, 23(5), pp. 522-538. [Online] [Accessed on 9th October 2017] <https://doi.org/10.1108/14777260910984014>

Wong, C. A., Cummings, G. G. and Ducharme, L. (2013) 'The relationship between nursing leadership and patient outcomes: a systematic review update.' *Journal of Nursing Management*, 21(5), pp. 709-724. [Online] [Accessed on 9th October 2017] <http://onlinelibrary.wiley.com/doi/10.1111/jonm.12116/full>

World Health Organisation (2014) *Operations Manual for delivery of HIV prevention, care and treatment at Primary Health Centres in high-prevalence, resource-constrained settings*. Geneva: WHO. [Online] [Accessed on 4th January 2018]

<http://www.who.int/hiv/pub/imai/om.pdf>

Yang, P-H., Hung, C-H., Chen, Y-M., Hu, C-Y. and Shieh, S-L. (2012) 'The impact of different nursing skill mix models on patient outcomes in a respiratory care centre.' *Worldviews on Evidence-Based Nursing*, 9(4), pp. 227-233. [Online] [Accessed on 16th June 2017] <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3533773/>

Yildirim, A. and Yildirim, D. (2007) 'Mobbing in the workplace by peers and managers: mobbing experienced by nurses working in health care facilities in Turkey and its effect on nurses.' *Journal of Clinical Nursing*, 16(8), pp. 1444-1453.

Yin, R. K. (2015) *Qualitative research from start to finish*. 2nd ed., New York: Guilford Publications.

Yip, K-S. (2006) 'Self-reflection in reflective practice: a note of caution.' *British Journal of Social Work*, 36(5), pp. 777-788. [Online] [Accessed on 2nd June 2017] <http://bjsw.oxfordjournals.org/content/36/5/777.abstract>

Yoder-Wise, P. S. (2013) *Leading and managing in nursing*. 5th ed., St Louis: Elsevier Health Sciences.

Zarshenas, L., Sharif, F., Molazem, Z., Khayyer, M., Zare, N. and Ebadi, A. (2014) 'Professional socialization in nursing: a qualitative content analysis.' *Iranian Journal of Nursing and Midwifery Research*, 19(4), pp. 432-438. [Online] [Accessed on 15th June 2017] <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4145501/>

Appendices

Appendix 1

Ethical approval from Manchester Metropolitan University

MANCHESTER METROPOLITAN UNIVERSITY
FACULTY OF HEALTH, PSYCHOLOGY AND SOCIAL CARE

MEMORANDUM

FACULTY ACADEMIC ETHICS COMMITTEE



To: Lorna Ford

From: Prof Carol Haigh

Date: 12/09/2014

Subject: Ethics Application 1244

Title: A phenomenological study to investigate nurses' experience of professional accountability

Thank you for your application for ethical approval.

The Faculty Academic Ethics Committee review process has recommended approval of your ethics application. This approval is granted for 42 months for full-time students or staff and 60 months for part-time students. Extensions to the approval period can be requested.

If your research changes you might need to seek ethical approval for the amendments. Please request an amendment form.

We wish you every success with your project.

Prof Carol Haigh and Prof Jois Stansfield
Chair and Deputy Chair
Faculty Academic Ethics Committee

Appendix 2

Letter of ethical approval from local NHS research and development committee

University Hospital
of South Manchester 
NHS Foundation Trust

Tuesday 13th October 2014

Dear Lorna,

Re: NHS to NHS Letter of Access for Research

Thank you for providing us with the following documentation:

- Curriculum Vitae
- GCP Training Certificate
- "Confirmation of Pre-engagement Checks" Form

As you already hold an existing NHS employment contract, you do not require an additional Honorary Research Contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring that necessary checks have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement checks are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access to conduct research at the [redacted] for the purpose and on the terms and conditions set out below, and for the following research studies:

A Phenomenological study to investigate nurse's experience of professional accountability R&D to be confirmed

This right of access is valid until 13th October 2015 unless terminated earlier in accordance with the clauses below.

You are considered to be a legal visitor to [redacted] NHS Foundation Trust premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research at University Hospital of South Manchester NHS Foundation Trust, you will remain accountable to your employer, [redacted], but you are required to follow the reasonable instructions of your nominated manager, [redacted] in this NHS organisation or those given on his behalf in relation to the terms of this right of access.





Manchester
Metropolitan
University

Appendix 3

Participants' information sheet

Lorna Ford
Post Graduate student
Birley Building,
Birley Campus,
53 Bonsall Street,
Manchester,
M15 6GX

Participants Information sheet

Study Title: *A Phenomenological study to investigate nurse's experience of professional accountability*

Dear Participant,

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Please do not hesitate to contact me if you would like further information or have specific issues regarding the study you wish to discuss. Please do take time to decide whether or not you wish to be involved in this study

What is the purpose of the study?

As part of an academic course to gain a PhD qualification, I am undertaking a qualitative research study, to look at qualified nurse's experience of professional accountability. The research will investigate nurses' everyday experiences of working in the NHS, and explore their experiences of professional accountability, professional regulation and management. The researcher has chosen to use a phenomenological approach which is a form of research which seeks to understand people's perceptions, perspectives and understandings of a particular situation (or phenomenon). The findings of this study will be used to enhance understanding of the 'lifeworld' of the nurse and offer insights which may be used to support nurses, through policy and education in the NHS.

Why have I been chosen?

I am interested in your experiences of working as a qualified nurse in the NHS, and any issues you have experienced in relation to your professional accountability.

What if I don't want to participate in the project?

Taking part in this research project is entirely voluntary. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and you will be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason.

What will be involved if I decide to take part?

If you agree to take part you will initially be invited to take part in an individual interview with the researcher. The interview will take place at a mutually agreed location and will last approximately 60 minutes. The interview will be audio taped and participants will not be identified at any time during the project. The researcher will transcribe the interview and use pseudonyms and codes to protect your anonymity.

Will my taking part in the study be kept confidential?

All information will be held in confidence, and your anonymity will be protected. However, you must also be aware that if you disclose a safeguarding issue, the researcher is professionally bound by the NMC to report this.

The data will be kept confidential and participants will not be identifiable from this.

Pseudonym's and codes will be used. The researcher will destroy all the data and recorded interviews once the project has been written up. The procedures for handling, processing, storage and destruction of data in this project will be compliant with the Data Protection Act 1998 and in line with MMU Data Protection Policy(2011)

<http://www.mmu.ac.uk/policy/policy.php?id=100>

What are the possible advantages/disadvantages of taking part?

Participation in this project will enable you to reflect on your unique experiences of being a qualified nurse working in the NHS. These experiences will allow the researcher to build up a greater understanding of the 'lifeworld' of the nurse and will add to the existing body of knowledge. This will help to support and inform professional development for nurses.

What happens when the research study comes to an end?

The recorded interviews will be stored on the audio recording device and on a written copy for the duration of the study: October 2014- June 2018. After this time they will be destroyed. Results of the study will be included in my PhD thesis. I am also required to submit an article for publication so this will be done at the end of the study. All data will then be destroyed confidentially. Participants are welcome to see a full copy of the thesis.

Ethics approval

As this study is part of an academic qualification, it will receive supervision by an experienced academic team. The study has been granted ethical approval by Manchester Metropolitan University research ethics committee.

Dissemination of study findings

The findings of this study will be published in my PhD thesis. Study findings will also be published in a professional publication. You will not be identified in any publication.

Contact Details:

If you require further information, or would like to ask any questions, my contact details are:

Lorna Ford MSc, BSc (hons), QN, RGN

Post Graduate student

Birley Building,

Birley Campus,

53 Bonsall Street, Manchester,

M15 6GX

If you have any concerns about the conduct of this research you can contact:

Professor Carol Haigh, Faculty Head of Ethics

Manchester Metropolitan University


Birley Campus

Tel 0161 247 5914

E mail c.haigh@mmu.ac.uk

Appendix 4

Consent form for participants

| | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
|  Manchester Metropolitan University | Consent Form | Lorna Ford PhD student Birley Building, Birley Campus, 53 Bonsall Street, Manchester, M15 6GX |
| Title of Project: A Phenomenological study to investigate nurse's experience of professional accountability Name of Researcher: Lorna Ford | | |
| Participant Identification Code for this project: | | <div style="border: 1px dashed black; width: 100px; height: 20px;"></div> |
| initial box | | Please |
| <div>1. I confirm that I have read and understood the information sheet for the above project and have had the opportunity to ask questions about the interview procedure.</div> | | <div style="border: 1px dashed black; width: 40px; height: 25px;"></div> |
| <div>2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason to the named researcher.</div> | | <div style="border: 1px dashed black; width: 40px; height: 25px;"></div> |
| <div>3. I understand that my responses will be sound recorded and used for analysis for this research project. I understand that my responses will remain anonymous.</div> | | <div style="border: 1px dashed black; width: 40px; height: 25px;"></div> |
| <div>4. I agree to take part in the above research project.</div> | | <div style="border: 1px dashed black; width: 40px; height: 25px;"></div> |
| <div>5. I understand that at my request a transcript of my interview can be made available to me.</div> | | <div style="border: 1px dashed black; width: 40px; height: 25px;"></div> |
| <div style="background-color: #cccccc; width: 150px; height: 30px;"></div> | <div style="background-color: #cccccc; width: 100px; height: 30px;"></div> | <div style="background-color: #cccccc; width: 150px; height: 30px;"></div> |
| Name of Participant | Date | Signature |
| | | |
| <div style="background-color: #cccccc; width: 150px; height: 30px;"></div> | <div style="background-color: #cccccc; width: 100px; height: 30px;"></div> | <div style="background-color: #cccccc; width: 150px; height: 30px;"></div> |
| Name of Researcher | Date | Signature |
| | | |
| <i>To be signed and dated in presence of the participant</i> <i>Once this has been signed, you will receive a copy of your signed and dated consent form and information sheet by post.</i> | | |

Appendix 5

Topic guide for interviews

Introduction

- A brief description of the research project will be given to the participant and a chance to ask any questions.

Warm up questions

- Questions will be asked concerning their job title, job location, and length of time qualified etc.

Broad theme: Culture

Prompts/probes

- Environment
- Morale
- Communication process
- Management structure
- Staff retention
- Workload
- Resources
- Personal feelings
- Work day experiences
- Gender

Broad theme: Effects on the NHS following the Francis report (2013)

Prompts/probes

- Staffing levels
- Resource allocation
- Management structure
- Change in attitudes
- Whistleblowing policy

Broad theme: Accountability

Prompts/probes

- Personal accountability
- Professional accountability
- Organisational accountability

Broad theme: Experience of professional regulation (NMC)

Broad theme: Experience of nursing

Prompts/probes

- Training
- Professional development
- Personal experiences
- Changes in nursing

Is there anything else that you would like to tell me?

Is there anything you would like to ask about the interview?

This topic guide will be used for the pilot interview and may need to be developed in light of the ongoing theoretical work as part of this PhD study. Any revised topic guides will be sent for ethics approval.

Appendix 6

Section of annotated transcript

| | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Researcher: Could you tell me a little bit about your experiences of being a nurse in the NHS, the highs and the lows.</p> | <p>Begins with nurse training. Hermeneutic Circle.</p> |
| <p>Marie: Well I have been qualified since 1976 and I am currently working in (Primary care service) in (Location)</p> | <p>Voice very assertive/ Anger/ Pain?/ regret ?</p> |
| <p>Marie: There have been big changes in the NHS, not always for the better.</p> | <p>Past-present. Part-whole.</p> |
| <p>I think the culture in the 70s was very different, for it was one of fear (pause), yes fear, although there was a lot of camaraderie. (Pause) The fear was of the ward sisters and the hierarchy. It was fear of being late and being untidy or if you had a hair falling out of place and a fear of things "that shouldn't be", like if the bed cradles were under the bed or on the floor, you know flowers being properly arranged and not dying in the vases. I think the patients were frightened as well of the doctors and the ward sister because I think it was, certainly in XXXX (location) where I trained, it was very strict and everything was done for cleanliness and efficiency, and patients did what they were told to do and we junior staff, certainly student nurses did what we were told to do.</p> | <p>Negative view/ Realistic</p> <p>Culture being different/changes</p> <p>Emphasis on word Fear</p> <p>Positive: camaraderie</p> <p>Fear used 5 times Fear of what ? Being late, Appearance, rules, new routine, 'of things that shouldn't be'! (Powerful description)</p> <p>Fear of specific things. (Heidegger)</p> <p>Unready-to-hand coping. All equipment named. Sees all environment/equipment (umwelt)</p> <p>Strictness for a purpose: Cleanliness, efficiency. (Justification)</p> |
| <p>Researcher: Hmmm</p> | <p>Follows orders/ Doesn't question. (Heidegger the-they. They-self. Conformity)</p> |
| <p>Marie: There was very clear hierarchies. Very clear demarcation and the ward sister certainly ruled everything that went on in the ward and I think that had a lot of positives and a few negatives, having said that, we student nurses, because we were counted in the numbers rather than being supernumerary meant we did club together if you like and support each other and defend each other. We had a lot of fun. (Pause)</p> | <p>Patients fearful too. No autonomy. No information/ Obeys orders/ not questioning. Conformity, the-they</p> <p>Oppression: fear of senior staff/ Medical staff</p> <p>Defined hierarchy/ Demarcation (Very rigid ? military) power: Ruled everything. (oppressive) Nothing could be questioned. Almost dictator.</p> <p>Positives?? Cleanliness/ efficiency/ camaraderie.</p> <p>Counted in the numbers gave sense of belonging (One of the ward) Club together/ support each other/ Fun</p> |
| <p>Marie: More recently since coming back into the health service around 16 years ago I think a lot of the regimentation has gone I think things are certainly more patient focused. Now it's focused on the individual rather than the ward and the routine. I think people are more approachable, but I think some of the good things have been lost and I don't feel that the ward is certainly as clean. I was horrified at the state of cleanliness of the wards it wasn't nearly as clean as it was in the 70s and 80s. Ward sisters now don't really have the power that they had. The cleaners on</p> | <p>Pauses to think— Moves onto present day, compares to 70's States positives. Adds BUT. Change of focus to negatives</p> <p>Regimentation gone, replaced by Patient centred care (Positive)</p> <p>People more approachable/ Fear reduced. Bear in mind she is older/ more confident/ understands rules/ routines Coping ready-to-hand (No detailed descriptions of equipment anymore)</p> <p>Misses cleanliness, despite routine of cleanliness being a cause of fear. Uses word horrified at current state of cleanliness (strong word)</p> |

| | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>the ward took pride in what they were doing and although they did report to their own supervisor they really were under the thumb of the ward sister and I know that there were daily routines carried out like floor washing. Nowadays you never see a floor washed, maybe you don't need to do it these days? There is far more furniture in the wards nowadays, everybody seems to have an easy chair by the bed and you know everything is done by the bed. I wasn't impressed by the state of the bathrooms or the shower rooms either, because our auxiliaries took great pride in keeping these things clean. The positive side of the NHS is that I think it's a far more open culture. I think patients are encouraged to be more involved in their care and everything is supposed to be more patient focused. It's a long way from perfect, but I think it's better in that respect. Another thing I have noticed is the amount of paperwork in nursing, certainly on the community the amount of scribing that you have to do that is very very repetitive at the same time, time consuming and this is morale seeping as well and this is in spite of computerisation which should have made things I think easier, instead, it seems to have proliferated the amount of scribing that we have to do you know. 16 years ago probably even 10 years ago the most technologically advanced piece of equipment in a (Primary care service) room was an answer machine and maybe one mobile phone and I don't think we even had our own fax, we had to get that through the doctor's surgery or whatever and so I think sometimes we're creating paper to satisfy things that are not related to good patient care or improve patient care or improved patient safety although it dressed up as that</p> | <p>Ward sisters power reduced Cleaners were under ward sisters 'thumb' Very strict. Cleaners took pride ? frightened Daily routines then, questions if this still happens or is necessary. Contradiction here as said cleanliness was worse.</p> <p>All patient activities done by bed ? sees this as a negative</p> <p>Auxiliaries ? used as cleaners in the past . Says 'our auxiliaries: sense of belonging to team</p> <p>Sees culture as more open, more patient involvement in decisions. Patient focussed not perfect but better</p> <p>Paperwork/record keeping</p> <p>Repetitive. Says very, very to emphasise its importance.</p> <p>Morale seeping Impacting upon patient care.</p> <p>Worse now IT</p> <p>Compares with past. Very little technology . Communication limited.</p> <p>Weights up costs</p> <p>Comes back to patient care</p> <p>Technology has made things more difficult. Concludes that paperwork is not improving patient care. Purpose to fulfil targets.</p> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Researcher: It's really interesting to hear you talk about the way nursing has changed. Do you think if you had problems in those early days of your career you could have spoken about it?</p> <p>It would depend what the problem was and I think if you had a problem, if you felt bullied for example: we all felt bullied but it was just part of the course you know. You were not singled out and you know the ward sisters, not all of them, but you know there were a few characters and few staff nurses as well where they would make your life hell. You were expected to do things in a certain manner and in double quick time and they weren't shy about yelling at you in front of the whole ward, but the plus side of that is that the patients always backed you up, they'd give you a sweetie or a kind word and certainly colleagues did as well and at the end of the day most of the things you got shouted at for were for the patient good, they weren't petty things. They would let you know if you'd left the bed cradle on the floor or if you didn't make a bed properly and certainly if you didn't clean the lockers. Mind you those things do have an impact on patient well-being and health. I think I would be able to bring something up certainly if it was to do with patient safety directly or if you were found out to do something that was detrimental to the patient's health then sure you'd be you'd be hauled up for it and you would be would have words if you saw somebody do something or or omit some thing .</p> <p>so probably it was harder to raise concerns, probably we weren't as focussed to be honest I think we didn't see things in the round in those days too I mean it was very task orientated but having said that we did care and we did give individual care. but you know you weren't inclined to whistleblow and you certainly weren't encouraged to whistleblow , and I mean I wouldn't take any pleasure in whistleblowing but if I saw something or I felt something wasn't right then I don't think I'd be shy about bringing up and I don't know many people I've worked with in the last 10 or 15 years who wouldn't actually.</p> <p>I think it would be difficult but I feel that people are more comfortable if you like about reporting things that they are not comfortable with and in my experience anyway certainly in the community (Pause)</p> | <p>I asked this because of her comments about power issues that were apparent in her early career. Wondered if she could speak about issues/ problems with senior staff. Careful use of terminology</p> <p>Depend what the problem was: Infers some things could be discussed. Not others.</p> <p>Bullying: Was conceived as the norm. Experienced being humiliated. Justifies by saying 'not singled out' Recognised that certain staff were renowned for being bullied. Why did it continue ?</p> <p>Rules, regimented. Carried out quickly. Punishment if not carried out correctly.</p> <p>Positives: Camaraderie from peers, patients. Patients backed you up Justification was that it was for the patient good. Not 'petty things'</p> <p>Rules: Bed cradles/ bed making/ lockers . The they</p> <p>Aware of equipment again. Fear again Justification : patient well being & health</p> <p>Could raise concerns if to do with patient care.</p> <p>Had to raise concern/ admit if mistake occurred.</p> <p>blame culture, If you failed to raise concerns you would be in trouble. In trouble if you make a mistake</p> <p>Hauled up / Have words = punishment. Could raise concerns depending on nature of concern</p> <p>Harder to raise concerns Back rounds/ Task orientated. Things not seen ?</p> <p>We did care .BUT not inclined to whistle blow. Connection of the two. Inclined/ encouraged</p> <p>No pleasure in whistleblowing ?</p> <p>Would raise concerns. All nurses would report concerns</p> <p>Difficult/ uncomfortable . more comfortable if causing problems</p> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|